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Health Care Benefits for State Workers: What Drives the Differences?

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HEALTH CARE BENEFITS FOR STATE WORKERS –

WHAT DRIVES THE DIFFERENCES?

By

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In any given week glance through the nation's leading newspapers and popular magazines and chances are you will find an article on the nation's medically uninsured. In chiding a country that allows 16% of its citizens to suffer the risks associated with that lack of insurance, reference is frequently given to the exemplary coverage provided to federal government employees by the Federal Employees Health Benefits Program. What of the benefits provided to state government employees? How good is the coverage, and, of particular interest, are there significant variations across states and what factors might contribute to those differences?

This study assesses the level of health care benefits afforded to state government employees in all fifty states and considers the potential impact of political ideology, political culture, economic conditions and public employee union membership in influencing variations in those benefits across the states. The state paid portion of a family's health care premium was adjusted to allow for differences in health care costs across the states resulting in a range of the level of benefits from

$318 per month in Mississippi to $1834 per month in New Hampshire. A state's economic condition, the level of public union membership, and a moralistic political culture were all shown to have a positive association with the level of benefits. Political ideology, defined as the degree of liberalism, was, however, not shown to have a statistical association.

Understanding health care benefit differences between states and the factors that drive those differences has the potential of improving lives and the functioning of state governments. Scant information on those differences exist in the current literature; this study has developed a baseline of information and an assessment of driving influences that will, hopefully, stimulate additional approaches and research efforts. Benefits, in general, have been shown in the literature to impact the ability of state governments to attract and maintain employees of merit. Advocates of increased benefits can utilize these study results to place their requests in a broader context.

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INTRODUCTION

In any given week glance through the nation's leading newspapers and popular magazines and chances are you will find an article on the nation's medically uninsured. In chiding a country that allows 16% of its citizens to suffer the risks associated with that lack of insurance, reference is frequently given to the exemplary coverage provided to federal government employees by the Federal Employees Health Benefits Program. What of the benefits provided to state government employees? How good is the coverage, and, of particular interest, are there significant variations across states and what factors might contribute to those differences?

The plight of the medically uninsured certainly has far greater individual impact than whether government employee in State A receives health benefit XX while government employee in State B receives health benefit YY. The uninsured may simply fall through the cracks failing to obtain medical care or obtain it substantially later in the disease process contributing to potentially negative health outcomes. Further, it has been shown (Shi, 2000) that the uninsured fail to gain the same quality of care as the insured. Nevertheless, the reasons for the differences between State A's employee health benefits and those of State B should provide insight into the impetus behind state employee benefit packages - packages that can assist state governments in their effort to attract and retain employees of merit.

The primary questions to be addressed by this research are:

- Are there significant differences in healthcare benefits provided to state government employees across the 50 states?
- If variations are found to exist, what possible factors contribute to such differences?

The answers to these questions will, hopefully, benefit the work of state employee benefit managers. The availability and affordability of health care is a significant concern in today's society; what we can learn from the differing degrees of what states provide for their employees, and the reasons for those differences, may offer insight into improving benefits for others.

It is particularly significant that this research is being conducted at this particular point in time. Facing ever escalating health care costs for their employees, state governments are looking at alternative forms of health coverage. Health savings accounts and tiered coverage plans (with multiple premium costs) are emerging as states attempt to balance employee expectations with increased financial pressures. As these and other forms of coverage emerge and gain acceptance with employees, the many diverse forms of coverage will increase the difficulty of the researcher in finding a common base and definition of coverage across states. Comparisons will be difficult at best and prone to potential measurement error. Now is the precise time to conduct this research and assess the factors that contribute to variations in benefit packages. Structural changes in offerings may impede future research. However, the contributing factors are likely to remain stable over a longer period of time even as it becomes more complex to measure the variation in the benefit itself.

This dissertation will assess the level of health care benefits afforded to state government employees in all fifty states. The research will consider the potential impact of political ideology, political culture, economic conditions and public employee union membership in influencing variations in benefits across the states. The following review of the literature will provide an understanding for the choice of factors thought likely to influence the provision of benefits.

CHAPTER II

REVIEW OF THE LITERATURE

Background

With the exception of a 2003 study by the Kaiser Family Foundation (see below), the literature has not addressed the question of differences in state employee health benefits among states. When attempting to understand the issue, there are four questions we need to consider before proceeding with the research: 1) Why is this an important issue? 2) What do we already know about it? 3) What might account for the differences? and 4) How might we best investigate the issue? In answering these questions it is necessary to look broadly through the literature focusing on related research such as employee benefits in general and the significance of health care benefits to government employees irrespective of differences between states. Partial answers will provide initial grounding for this research effort.

Before looking at these questions, it is beneficial to look at the origins of employer-based health care insurance and to assess the motivations behind providing such benefits. Perhaps one of the earliest recorded instances of "health insurance" in the United States took place in 1798 when the United States government required the owners of merchant ships to develop a "sickness fund" and deposit twenty cents per month for each seaman they employed ("History", 2003). This, however, was in reality more akin to disability insurance. As Thomasson (2000) has noted, health insurance, as we think of

it, did not truly develop in the United States until the 1930s. Prior to that time, medical technology was at such a primitive stage in its development that the true costs of illness were dominated by loss of work, not medical expenses.

It is often assumed that war time wage freezes, excess-profits tax and tax-exempt status of health insurance payments led to the growth in employer-sponsored health insurance (Glied, 2005). However, Dobbins (1992), utilizing data from the National Industrial Conference Board (NICB) between 1928 and 1946, disputes the general belief that benefits (pensions and health insurance) rose in response to wartime federal policy changes and industrial factors. His findings show that the rise in health benefits preceded the war-related wage freeze, excess-profits tax, and benefit tax exemption rules. In fact, for businesses with fewer than 250 employees, the prevalence of health and/or accident insurance rose from 11% in 1928 to 25.7% in 1939 and for businesses with more than 250 employees the prevalence increased from 15.5% in 1928 to 38.3% in 1939 (p. 1424).

The theory advanced by Dobbins "links public policy to interest group goals and in turn to organizational outcomes" (p. 1445). He sees "interest group goals as an intermediate variable between environmental context and organizational outcomes" (p. 1445). Case law arising out of the Wagner Act led businesses to want to increase insurance to "subvert unionism" (p. 1434) while unions fought to win the rights to bargain over fringe benefits. Thus, to Dobbins, the primary impetus behind employer-sponsored health insurance is the desire to increase employee loyalty to the organization.

While Dobbins built a strong case for the pre-war growth in benefits and the desire of industries to build worker loyalty, he did not adequately diffuse the attribution of benefit growth emanating from the war-related wage freeze, excess-profits tax, and

benefit tax exemption rules. Though he established a growth trajectory prior to the war related economic policies, he did not explain the greater expansion of benefits during the war years. From 1939 to 1946 health and/or accident insurance grew from 25.7% to 53.3% for smaller firms and from 38.3% to 67.2% for larger companies (p.1424).

In either case it would appear that the provision of health care benefits was perceived by industry as a means of increasing worker loyalty and that various public policies, whether socially driven (Wagner Act) or economically motivated (war time policies), served as an incentive for industry action benefiting workers.

Why is this an important issue?

In terms of importance, numerous studies have verified the significance of employee benefits in attracting and retaining public service employees. Light (1999, p.96), in a study of what motivates public servants to serve, found that 25% of respondents (graduates of the country's top public policy and administration graduate programs) ranked benefits as a "very important consideration" on their first job, while 41% ranked them as a "very important consideration" in their current position. The increase is likely reflective of the growing importance of benefits as individuals age. Investigating the relative importance employees place on various job values, Karl and Sutton (1998, p.521) found public sector employees ranked benefits as number five out of a list of sixteen potential values. In a more recent study, Light (2003) found that 19% of college seniors had given very serious consideration to working for state or local government. Survey results were analyzed of a random sample of about-to-graduate liberal arts and social work students. Government was viewed as most attractive for

someone who wanted good benefits. In terms of attributes valued in a job, benefits ranked second with 63% of respondents saying it was an important consideration. Benefits ranked behind opportunity to help people (67%) and tied with opportunity to do challenging work, but placed substantially ahead of salary that garnered a mere 30% response rate.

Based upon a 1991 Gallup poll, Caggiano (1991) reported that 81% of respondents (public and private sector individuals) ranked health insurance and other benefits as very important job characteristics compared to 78% for interesting work and 56% for high income. Additionally, only 27% said they were satisfied with their current level of health insurance and other benefits.

In a study of employee attitudes toward benefit packaging, Fredericksen and Soden (1998, p.29) found that 84.7% of the surveyed public sector employees in El Paso perceived health insurance benefits as of "great importance". In a listing of twenty-seven benefits available to public employees in a large Midwestern city, Bergmann, Bergmann and Grahn (1994, p.401-403) found health care ranked second in general importance behind retirement; fringe benefits as a whole were rated as between "very important" and "extremely important" in retention. This finding relates to Selden and Moynihan's (2000, p.63) observation that state human resource management practices impact state quit rates. The 1997 turnover rate in state government was approximately 8% compared to approximately 6% in the private sector. The quality of the employees that exit produce additional concerns. In a 1997 study of public sector employment exits, Crewson found voluntary exits from state government scored 4.3% higher on the Armed Forces Qualifications Test, utilized in the National Longitudinal Survey of Youth (NLSY), than

those who had not voluntarily left state government. The depletion in quality is greatest at the managerial level where there was nearly an 18-percentile score advantage for those voluntarily leaving over those who did not voluntarily exit. The one other statistically significant finding was a 6.7% score advantage for the male voluntary exiters, across all categories of state public employment, above those who did not voluntarily exit. If, as Selden and Moynihan contend, state quit rates are impacted by human resource management practices, then deficient health care benefit packages could contribute to a diminishing quality of state employees in light of the NLSY results.

For employees that stay, Daley (1998, p.7) states that health insurance can aid in alleviating "health-related threats to motivation and productivity". Hayes and Kearney (2001, p. 591), in a survey of public personnel managers, ranked health care benefits as being of the greatest importance to the practice of human resource management both in the year 2000 and, as they looked ahead, in 2008.

Reflecting upon Maslow's (1943) seminal work on human motivation, if you conceive of health as a physiological need and health care benefits as a safety need then when either of those are in jeopardy you are blocked from love (affection and belongingness), esteem (self-respect, self-esteem, and the esteem of others) and self-actualization goals (becoming all that one is capable of becoming). McGregor (2001) has said, "Since every industrial employee is in a dependent relationship, safety needs may assume considerable importance." (p.180). Herzberg (1968) focuses on the benefits of motivators, and does not adequately address the actual impact of hygiene factors such as benefits. He does, however, state, " Unless the ante (referring to fringe benefits in general) is continuously raised, the psychological reaction of employees is that the

company is turning back the clock." (p.55). Hygiene factors are maintenance factors; by themselves they do not provide satisfaction, but are seen by Herzberg as necessary for avoiding dissatisfaction. Health care benefits clearly play a role in employee contentment and can, theoretically, be a source of dissatisfaction.

Though Herzberg failed to deal with the consequences of job dissatisfaction, Withey and Cooper (1989) utilized dissatisfaction to predict exit, voice, loyalty, or neglect as strategies adopted by graduates of a Canadian college school of business employed throughout North America. The researchers found that individuals were more likely to consider and actually leave an organization if they perceived the costs of leaving were low, thought the risk of voicing their dissatisfaction too high, lacked hope that the current situation would improve, were not committed to the organization, and had a viable career alternative available. The authors did not provide demographic information, leaving one wondering if exiting may be a strategy more likely utilized by younger people with less vested in a position and an organization. Neglect may be a more likely outcome for a more experienced employee where the cost of exiting is high. Neglecters tend to hurt an organization from within and not leave though they perceive conditions as better elsewhere.

Beyond state employees themselves, might others be impacted by the variation in benefits across states? In a discussion by Glenn (2005, p. A21-A22), relating to colleges' and universities' difficulties with the growing cost of health care coverage, he maintains that some educational institutions have addressed the problem with increasing tuition, thus impacting the broader public. Further, he cites health care benefits as central to

recent strikes at Northeastern Illinois University and the City Colleges of Chicago and as an impetus to the growth of unionism in higher education.

With rising health care costs and sluggish state economies, improving benefit packages may be a difficult task for a state to accomplish. In fact, in Streib's (1996, p.69) study of health care plans in municipal governments, a decline in benefit levels was noted in the public sector. What was of particular interest to Streib was the lack of research or debate in the public administration literature relevant to the emerging cutbacks in benefits; this was cited in stark contrast to the continuous discussion of this topic in the private employment sector. In a similar vein, Davis and Ward (1995, p. 257) maintain that minimal research has been conducted on equity considerations in reference to employee benefits. Allocation and perceived fairness of allocation of benefits may, according to the researchers, be strong determinants of job satisfaction in both the private and public sectors. Given the growing costs of health care coverage, and the resulting need to change means and levels of coverage, benefit satisfaction may play an increasingly important role for employers' consideration. Vroom (1964), in his early writings on equity and job satisfaction, did state that though rewards were most frequently interpreted to mean wages, the model was applicable for any form of reward.

Adams' (1965) theory of inequity assumes that whenever an individual perceives that the ratio of his or her outcomes to inputs is unequal to the ratio of another's outcomes to inputs that dissatisfaction will arise from the state of inequity. Further, the individual will be motivated to either achieve equity or reduce the degree of the inequity. In a study of clerical workers in an industrial setting, Dittrich and Carrell (1979), found a significant relationship between employee perceptions of equity and absence rates. Additionally,

they found a significant relationship between absence rates and employee turnover. However, they postulated that the decision to leave an organization permanently may be more directly affected by the availability of external opportunities. Though there was a relationship between absence and turnover, none of the fairness (i.e. equity) variables in the study were statistically significant with turnover. While equity theory is frequently linked with commitment in the literature, Scholl (1981) argues that the two are separate independent variables; he maintains that an individual who perceives her or himself in an inequitable situation may well still remain "committed" to an organization for such possible reasons as personal investment in the organization, reciprocity, lack of alternatives, and identification amongst others.

How might the theory of inequity work within state government? Who is the "referent other" that a state employee would use for comparison purposes? Would an employee in Mississippi perceive inequity if they thought the health benefits for state employees in Minnesota were significantly better? Pritchard (1969) contends that an internal standard exists by which one measures if his or her own inputs are greater than his or her own outputs. Based upon this internal standard, an individual will experience discomfort whether or not comparison individuals are seen to be in a similar situation. The internal standard arises from an individual's "past experience in exchange relationships and his knowledge of the 'market value' of various inputs." (p 205-206). In studying the impact of inequity on the health of Finnish workers, Taris, Kalimo, & Schaufeli (2002) found the internal standard performed at least as well as the interpersonal equity measure.

If a referent other is being used, rather than an internal standard, Pritchard (1969) points out another consideration is the proximity of the "other" used for comparison. The more distant, the less likely the individual will be sensitive to over-reward (the individual considers him/herself overly rewarded for their inputs compared to the other), but under-reward always leads to dissatisfaction. Williams (1995) in a study of benefit satisfaction amongst public librarians suggested that,

> Although an employer cannot choose the referents that employees may decide to use, employers could provide data on benefits provided by comparable organizations in order to influence these comparisons. To the extent that these comparisons are favorable for the employer, benefit level satisfaction may be enhanced. (p. 1122).

Thus, we might postulate that employees with less rigorous health insurance packages might perceive themselves in an inequitable position whether they are making a direct comparison to another individual or basing it on an internal standard. Taking Williams' advice, states with above average benefit packages might provide comparison data to ward off potential senses of inequity. Though it is reasonable to assume that a state government employee in a particular state is probably more likely to compare his or her health benefits with those in the local labor market, knowledge of benefits provided to state government workers in other states might influence ones internal standard of measurement.

The framing of public service benefit packages is an important consideration. The quality of coverage and the variance between states is an issue worthy of the attention of public administration research; contrasts with the private sector may be helpful as well. In a 2005 symposium on benefits, Paddock said:

> In an era of a compressed workforce and increasing competition for good workers, and where health and retirement plans in the private sector are threatened, even bankrupt, benefits may be the factor that attracts and keeps good employees. These benefits should be considered a public sector advantage instead of a burden. (p. 300)

Paddock's words are particularly noteworthy when considered in combination with Lewis &Frank's (2002) finding that between 1988 and 1998 there was a one-third drop (from 28% to 19%) in the number of respondents to the General Social Survey (GSS) that professed a preference for government versus private sector employment. Add to that the factor that in a 2000 survey of Georgia state employees (Kellough & Nigro), only 57.7% of respondents thought their benefits were competitive with those available in the private sector.

Another aspect of importance is the potential impact of state governments on the health care market place. Maxwell, Temin, and Petigara's (2004) research, based upon a 2002 survey, indicated that state governments purchased health insurance for more than 4 million employees and retirees, millions more dependents, and approximately 1.5 million individuals associated with other public agencies, state universities, municipalities and, in some instances, children in state-subsidized programs. A report by the Milbank Memorial Fund (2005) stated that health care-related expenditures for state government employees totaled $26.8 billion in FY 2002 and grew to $29.4 billion in FY 2003. The totals represent the amount state governments paid for health insurance premiums for their employees, the medical portion of workers' compensation, the Medicare payroll taxes paid on behalf of state employees as well as employee contributions to health insurance premiums and to flexible spending accounts; more than 70% of the totals are attributable to health insurance premiums alone ($19.1 billion in FY 2002 and $21.2

billion in FY 2003). Such spending represented 2.5% of total state spending in FY 2002 and 2.6% of total state spending in FY 2003.

Towers Perrin (2005) in a survey of employers in the private sector, found an anticipated average increase in health care expenditure of $597 per employee in 2006. Of that, it was expected that $442 would be borne by the employer and $155 by the employee. Between 2000 and 2005, the Kaiser Foundation (n.d.) reports that insurance premiums in the private sector grew by 73% while cumulative inflation advanced by approximately 14% and cumulative wage growth registered 15%.

The amount of money flowing into the health care marketplace is also a reflection of the nation's tax bill. As Woolhander and Himmelstein (2002) point out, when the Centers for Medicare and Medicaid Services publish the government's share of health spending in the country they do not include public employees' health benefits. Public employee health benefits (federal, state, and local) cost taxpayers $52.4 billion in 1999 and represented 5.4% of the nation's total health care expenditures. The federal government is the largest purchaser of private health insurance in the country, followed by the state of California.

In addition to today’s rising health care costs, what of tomorrow’s? A recent Governmental Accounting Standards Board (GASB) ruling requires state governments to report the costs associated with post-employment benefits. Unfunded liabilities for the future health care and non-pension benefit costs of current employees and emerging Baby Boomers may be substantial. A study by Credit Suisse indicated that such underfunding could be in excess of $50 billion in California, New Jersey and New York. Variations are significant across the states with Mississippi, Nebraska, and Wisconsin having apparently

no unfunded liabilities and those for North Dakota and Wyoming being estimated at less than $100 million (National Conference of State Legislatures, 2007).

Taking the economic impact down to the individual employee level, the Health Confidence Survey of 2007 (Employee Benefit Research Institute) found that 63% of Americans with health insurance experienced an increase in costs they were responsible for paying in the past year. The increase in costs led 30% of those affected to reduce their contributions to retirement saving and 53% to reduce other savings. Additionally, the increased costs resulted in 36% having difficulty in paying bills, while paying for basic necessities impacted 29% of those experiencing health care cost increases.

Increased costs or not, however, employer-provided insurance remained critically important to those with such coverage. Given a choice between $7,500 in additional taxable income or $7,500 in additional health benefits, 76% chose the additional benefits. Those preferring to keep their coverage responded that it would take an additional $12,000 (median response) in taxable income to give up their current coverage.

What do we already know about it?

The Federal Employees Health Benefits Program has frequently been cited as a model for health system reform, but relatively little research has looked at the health benefits of state and local public employees. The 1997 Robert Woods Johnson Foundation Employer Health Information Survey did find that state governments contribute more to the cost of employee health insurance premiums than do private sector employers (Long & Marquis, 1999).

A 2003 study by the Kaiser Family Foundation confirmed the Robert Woods Johnson findings; Kaiser observed that state governments pay 5% more of the average single employee premium and 4% more of the average family premium. This increased proportion is, however, somewhat mitigated, at least in terms of individual coverage, by an 8.2% higher single employee total premium for state government employee coverage; total family premiums average 3% lower for state governments as compared to the private sector (The Kaiser Family Foundation, 2003, p.2). More interestingly, for the purpose of this research, was the range of premium rates; the total monthly family premium varied from a low of $429 in Montana to a high of $1110 in Maine (p.7). The difference in premium rates is likely to be indicative of differences in benefit coverage and structures between states.

In a further comparison between the private and public sector, the Kaiser Foundation (n.d.) has shown that the percentage of premium increase costs of large public purchasing programs such as FEHBP and CalPERS has largely mirrored that of private employers, showing a similar general pattern from 1993-2003. An exception was noted for CalPERS in 2002 and 2003 when its percent increases were significantly higher than the private sectors and FEHBP's. If there were a variance between states in their ability to contain costs this could well affect the benefits offered. In a later Kaiser Foundation study (Gabel et al, 2005) it was noted that private sector premiums rose 9.2% from spring 2004 to spring 2005; this increase outpaced both the overall inflation rate and workers wages each by almost 6 percentage points. Since 2000, health care premiums in the private sector have risen 73%. Strunk and Ginsberg (2003), commenting on a Towers Perrin employer study in the private sector, noted that while cost sharing increases in

premiums were being passed on to employees the proportion of the total they were required to pay was being held fairly constant (approximately 22% for family coverage).

In a 2005 study of Bureau of Labor Statistics data, McDonnell found that total compensation costs were 46% higher per hour worked for state and local government workers as compared to private sector employees while employee benefit costs were 61% higher. Most interestingly, health insurance benefits were 123% higher and averaged $3.66 per hour worked for state and local government employees as compared to $1.64 per hour worked for private sector employees. Braden and Hyland (1993) attributed differences in wage and benefit costs of public and private sector employees to various factors, most particularly differences in work activities and occupational structures. Given government's need to provide for public education and safety they employ a larger proportion of white-collar professionals and highly skilled service occupation personnel.

In contrast to McDonnell's findings on wage rates, Watts, Christianson, Heineccius and Trude's (2003) analysis of the 2001 Community Tracking Study data indicated that public employers perceived public wage scales as lower when compared to private wages. This led the public employers to the conclusion that benefits were playing an increasingly important role in attempting to develop a competitive compensation package. Further, the researchers reported the belief that public employers "raised the bar" on what plans were offered in the private employment market (p. 176). Anecdotally, reference was made to the potential of public employers being concerned about their impact on players in the health care market. The authors cited an example of New Jersey possibly making less than financially advantageous choices in constructing their employee health benefits out of concern that they could disrupt the local employment

market. New Jersey has a significant number of health care and pharmaceutical employers located within the state.

Though seen as "raising the bar" on benefit packages, the authors also cite a concern by public employers that they are losing their leverage in negotiating with insurance plans. As the total number of available plans shrinks, government employees represent a smaller percentage of a plan's insured. Though 33% of CalPers (the California public employees' insurance organization) members are enrolled in Kaiser plans, they represent only 5% of Kaiser's membership (p.177). The result has been CalPers considering reducing the number of offered plans or moving to one self-funded state plan. Market pressures such as these obviously have the ultimate result of limiting employee choice.

As in the New Jersey example cited above, the financially advantageous choice is not always made. The Louisiana state legislature has prohibited the state health plan from utilizing mail order pharmacies in their benefit offering. Though the mail order option would reduce administrative costs and provide the state with an ability to negotiate greater discounts and rebates, retail pharmacies successfully lobbied their case with state lawmakers (National Association of State Personnel Executives, 2006).

Whether consistently making financially advantageous choices or not, costs are rising for the states. Based upon a survey of state government human resources managers conducted by the International Public Management Association for Human Resources on healthcare benefits cost management in state and local government, Chiapetta (2005) reported that 41% of respondents reported a cost increase of between 11 and 20% from 2002-2005; 48% reported increases in excess of 20%. Given the escalating costs, 90% of

public agencies either had or intended to make changes in their health care plans within the next year. The key strategy employed by those that had made changes in the last three years was cost shifting to employees. Examples provided were:

- 33% increased employee premium and office visit co-pay amount.
- 30% increased deductibles
- 20% increased both employee share of the premium and reduced the benefit plan structure
- 17% increased employee payments for coinsurance

Hurley, Felland, Gerland, and Pickreign (2006), examining data from the 2005 Community Tracking Study, likewise found some public employers have initiated design changes in an attempt to control or moderate costs. One example incorporated tiered employee premiums, wherein the University of California system initiated a graduated premium contribution plan based on salary/wage ranges with four different levels. South Carolina and Arkansas have begun offering high deductible health plans in conjunction with health savings accounts; the take -up numbers in South Carolina were merely 100 out of 30,000 eligible. Nevertheless, minimal structural changes were observed. In addition to the University of California, Workplace Economics, Inc. (2005), reported that Illinois, Kansas, New Mexico, and West Virginia had initiated plans where employee premium payments were keyed to salary levels.

Overall, Reddick (2007) found that state and local governments provide higher cost health care coverage, but fewer plan and alternative care options than the private sector. The state and local government offerings did not incorporate as many HMO, PPO and

POS options, nor were they as likely to offer high deductible health plans or health care savings accounts as those available in the private sector.

As we look to state governments to see the issues and decisions surrounding the provision of health care benefits, it is necessary to consider where those decisions are reached. According to Berry (2000), all states, with the exception of Texas, have a centralized personnel function and within forty-seven of the states primary responsibility for personnel functions, including benefit determination, reside within a single personnel office. Boulard (2004), referencing D. Cauchi of the National Council of State Legislatures, said that though the executive branch in all fifty states oversees the employee health insurance plans, legislative involvement may be seen in such policy determinations as who is eligible and what portion of premiums will be paid by the employee. Additionally, legislatures may have considerable leverage when appropriating the annual funds to sustain employee insurance programs.

What might account for the differences?

The dissertation will look at differences in political ideology, political culture, economic conditions, and the role of pressure groups in influencing variation in health care benefits across the states.

Political ideology

Political ideology has been defined by Burden, Caldeira and Groseclose (2000) as "a latent set of values that organizes personal political attitudes" (p. 237). The dominant ideologies in the United States are generally referenced as liberal and conservative.

Researchers have argued that public sentiment shifts in favor of a more liberal policy agenda in expectation of (Durr, 1993) or in the face of (Stevenson, 2001) a strong economy. Conversely, a more conservative policy agenda is supported in anticipation of, or in light of, a declining economy. Wright, Erikson, and McIver (1987) contend that the expression of policy ideology by a state legislature is manifested over time and shaped by multiple legislative decisions. They maintain that the enactment of the most liberal policies is associated with the most liberal states as are conservative policies with conservative states. In later research (Erikson, Wright and McIver, 1989), they conclude that the ideology of the state legislature helps to determine the direction of state policy; however, the ideological bent of the legislators is tempered by state public opinion. Barilleaux, Holbrook, and Langer (2002) argue, however, that the degree to which liberalism or conservatism is expressed in policy consequences is a result of both inter-party competition and legislative balance. The example proffered is that "Democrats that dominate state legislatures but were elected in close races exert greater changes in welfare spending effort than Democrats with identical numbers of seats who were elected under less competitive elections" (p.415). Their findings indicate that supposedly liberal parties may temper their ideological bent based upon the degree of electoral competition. Coggburn and Schneider (2003) developed a model that indicated that 51% of states' policy priorities were influenced by the combined effects of government ideology, citizen ideology, size of state government, and management capacity; each of the independent variables proved to be statistically significant at the .05 level.

How ideology is expressed may be debated, but as Erikson and Tedin (2003) have stated , "…to have the liberal conservative spectrum as a political frame of reference is

necessary to understand the language of politics as it is practiced by political elites." (p.74). Political ideology also may play a more dominant role in reference to some policy areas versus others. Kingdon (2003, p. 134), in his study of national policy making, found that health appeared to be subject to a greater ideological bias than transportation.

Political culture

Separate from ideology is the concept of a political culture. In an effort to assist researchers to better define ideology, Gerring (1997) maintains that frequently the term ideology is misused when political culture would be the more appropriate term. In distinguishing between the two terms, the author states, "Political culture is generally considered to be less dogmatic, less action-oriented, referring as much to political procedures as to the substance of politics, and is much more likely to be defined as a set of (unconscious) practices" (p. 982).

Elazar (1966, p. 79) defined political culture as "the particular pattern of orientation to political action in which each political system is imbedded." This pattern of orientation emanates from the "historical experiences of groups of people" (p.84). While the United States as a whole may be seen as having one general political culture, Elazar maintains that this is an amalgam of three distinct subcultures that can be defined and which reflect migration and settlement patterns of distinct groups of immigrants. The three subcultures are designated as individualistic, moralistic, and traditionalistic. Though variations and combinations occur within parts of a state, Elazar has assigned a dominant political culture to each of the states (see Appendix Table E.1). The

individualistic culture model accentuates private concerns and believes in limiting government action to functions demanded by the public and, primarily, actions that encourage private initiative. The model representative of a moralistic political culture sees government as a positive instrument in promoting the public good; it represents a more activist government involved in attempting to improve economic and social conditions. The third model, the traditionalistic political culture, assumes a hierarchical society wherein government is dominated by those at the top of the social order; their goal is to maintain the existing social order.

Though the conceptual modeling of "political culture" is most frequently attributed to Elazar, Kim's (1964) research indicates that the term was in fact first used by Almond in 1956. Almond (1956) defined political culture as "a particular pattern of orientations to political action" (p. 396). In subsequent works, Almond (1989) maintained that such values as civic obligation and trust were affected by the historical and life experiences of a nation and groups within nations. This resonates with Elazar's conclusion that political cultures are influenced by migration and settlement patterns.

The concept of political culture and the staying power of Elazar's initial state designations have been debated in the literature. It is, to begin with, as Gray et al (1999) have said, intuitively appealing to many researchers; "it is consistent with general impressions about state differences in political values, style, and tone" (p.24). Abramowitz (1989) saw Elazar's categorizations (moralistic, traditionalistic, and individualistic) as "largely impressionistic" yet worthy of further study (p.184). However, a common criticism of Elazar's categorization is an assumption that political culture remains constant over time. Morgan and Watson (1991), expanding upon

Johnson's earlier work (1976), contend that religious data is an enhanced proxy for state political culture and would shift a number of states from moralistic and traditionalistic models to the individualistic model. Hero (1998) criticizes Elazar's reliance on the migration patterns of Europeans that Hero views as discounting the political values and beliefs of non-Europeans and racial minorities. African American influence is minimized and recognition of increasing immigration of Latino and Asian populations since the 1960s is, according to Hero, not addressed. Disputing Hero's emphasis on the impact of the distribution of racial and ethnic groups, Sharp (2005) does see the emergence of "new political cultures" or "unconventional cultures". However, the researcher attributes the strength of these new constructs to such postindustrial characteristics as increased educational roles, changing women's social roles, nontraditional household arrangements, and decline in traditional religious attachments.

Various scholars take the approach of faulting aspects of Elazar's schema, but accepting that the basic differences do exist. Dye (1988) points out that there is an increasing homogeneity of state and regional cultures brought about by increased mobility, national television, movies, and music. However, he contends that sufficient variation exists to merit comparative analysis. Lowery and Sigelman (1982) contend that Elazar failed to present evidence that the mass publics of the states did in fact hold the attitudes core to the defined political subcultures. Further, their analysis of NES survey data led them to the conclusion that, in terms of attitudes related to mass political participation and scope of government policy making, distinctions between the three cultures as designated by Elazar were not very strong. They did, however concede that,

> Even though the mass publics of the three cultures may not vary systematically in their basic political attitudes, it nonetheless remains possible that political elites - those who exercise the greatest influence on public policy making - do develop certain deeply rooted political orientations, which are tied to basic cultural values. (p. 383)

The assumption that perhaps the actions of political elites, as opposed to general public opinion, are more representative of political cultures was an earlier finding of Welch and Peters (1980) and Schlitz and Rainey (1978). However, Savage (1981) has disputed Schlitz and Rainey's discounting of the general public's placement within Elazar's subcultures, contending that their methodology emphasized an assessment of current situations rather than core values.

In terms more specific to this research, Fitzpatrick and Hero (1988) found that moralistic states made greater use of merit systems and demonstrated greater economic equality among its citizens. If we consider these outcomes to be surrogates for fairness to employees, we may see a similar effect in the provision of health care benefits. Sharkansky (1978, p. 40) claims that states scoring high on moralism tend to have large numbers of public employees that receive high salaries and generous benefits. In a study of state and local government expenditures, Miller (1991) found a positive association between higher state expenditures on health programs and states with a moralistic culture. It was particularly noteworthy that the researcher found that the states with a moralistic culture did not vary significantly in their total spending even though their tax capacity, population density, heterogeneity, and income was less than that of the individualistic states. Part of this is a reflection of the finding that expenditures are generally higher for state governments and lower for local governments in moralistic states, whereas the

opposite is true in individualistic states. This finding has obvious implications if we are looking at benefits provided at a state level.

Boekelman (1991) sought to understand the impact of political culture on state economic development policies. One interesting finding was that, as expected, states with a moralistic culture were more inclined to support policies focusing on citizen-oriented opportunities such as increasing high-quality jobs rather than ones focused on business incentives; however, there was a variation between the more industrialized and the more rural of the moralistic states. Greater policy efforts were evident in the more industrialized states. Boekelman attributed this difference to the possibility that unionization in an industrialized state offers the potential for additional political leadership on policy issues. Along with Welch and Peters (1980) and Schlitz and Rainey (1978) cited earlier, Boekelman appears to agree with the proposition that the impact of political culture is more evident in the behavior of political elites than in that of the mass public. He finds this to be particularly true in addressing complex issues.

A more current look at state budgets in relation to Elazar's construct can be found in the work of Koven and Mausolff (2002). In an initial cut at the data, they showed differences in the average per capita expenditures for the three types of political cultures for various categories of state government expenditures between 1992 and 1996. The moralistic states expended the highest average per capita amount for all categories, including the health, hospital, and public welfare classifications. Though this method of analysis controlled for differences in population size it did not address the influence of economic conditions and political variances. A model was constructed that controlled for the impact of income, legislative party affiliation and urbanization. The results continued

to show the impact of political culture on state spending with a $264 per capita spending difference between each category when viewing total state expenditures. When tested on individual categories of spending, political culture was significantly correlated only with educational and hospital spending. The authors conclude, "Despite the age of Elazar's cultural system and ongoing demographic changes, the culture-expenditure link remains intact" (p. 74).

Adding credence to the significance of political culture is Erikson, McIver, and Wright's (1987) analysis of CBS/New York Times public opinion survey data collected between 1976 and 1982. The researchers concluded that state political culture, defined as "that portion of public opinion that cannot be accounted for by the group characteristics of the state electorate", dominated state demography as a basis of state-to-state differences in opinion (p.798). Partisanship and ideology were not mere derivatives of a state's demographic composition, but reflective of the distinctive political context of a given state. Rosenthal (1984) sees elements such as life experiences and environmental variables as the sources of political culture with the outcomes being actions, institutions, and policies. Similarly, Morris, Travis, Breaux, and Poulin (2002) found that "political culture is something other than an agglomeration of other variables" drawn from the political culture literature such as political, economic, and socio-demographic factors (p.15); political culture was found to be about attitudes.

Economic conditions

Turning to the potential impact of economic conditions, Roberts (2001, Public Personnel Management), in a study of New Jersey local governments, showed that local

government attempts to manage the growing costs of health care benefits were focused on displacement rather than structural solutions. Such tactics as higher taxes and increased employee co-payments were favored over solutions believed more likely to reduce total costs such as benefit consortiums and self-insurance. It would seem that such approaches, if followed by state governments in tight economic conditions, would likely trigger a greater reduction in the level of benefits.

In a study of state Medicaid spending, Buchanan, Cappelleri & Ohsfeklt (1991) measured the impact of both economic conditions and political ideology on the level of expenditures. The researchers found that economic conditions, rather than ideology, had a significant impact on state Medicaid spending levels. It will be interesting to see the similarities or differences when these factors are applied to public employee insurance versus that for the states' poor and disabled.

In contrast, Jacoby and Schneider's (2001) study of state program expenditures in 1992 showed no linkage between state policy priorities and state wealth, generosity, and/or funding sources. These researchers found policy priorities to be largely determined by public opinion and interest group activity within the states. Hwang and Gray (1991) differ and see that wealth, defined as the per person capita income, is an important determinant of state spending.

The potential impact of economic conditions on public employees' health care insurance can, however, be seen in Holahan et al's (2004) study of state responses to their 2004 budget crises. A number of the states studied responded to the demands of a slow economy by increasing the proportion of insurance premiums paid for by state workers. Anecdotally, Michigan threatened layoffs if the changes were not accepted by the state

employee's unions. Perhaps economic conditions will also be seen to moderate any potential affect of pressure groups. In a national study of municipal government benefit managers, Roberts (2001, Public Performance & Management Review) noted that health benefits were the number one benefit practice cited as contributing to fiscal stress, mentioned by 82.4% of respondents. (p. 394).

Rising health care costs in the face of fixed and declining state budgets are, as Maxwell, Temin, and Petigara (2004) have pointed out a particular problem since state governments, unlike the federal government and private enterprise, are required to balance their budgets annually. The researchers cite the National Governors Association claim that state deficits in 2002 amounted to $30 billion and were estimated to grow to approximately $82 billion in 2004. At the same time, states were anticipating double-digit percentage increases in health care costs in the coming years. However, since those projections were made, the National Conference of State Legislatures (n.d.) has reported that state budget conditions are improving albeit being tempered by increasing demands for spending. By the end of the first quarter of FY 2006, nineteen states were reporting budget overruns in comparison to twenty-three at the same point in FY 2002. When the Center for Studying Health System Change (Regopoulos & Trude, 2004) surveyed private employer's responses to a slowing economy and rapidly increasing health insurance premiums, they found employers tending towards incremental changes. The major strategy employed was towards a moderate increase in employee cost sharing. It was noted that unlike in the early 90's when many thought managed care would be a new panacea, employers generally failed to see any significant innovative approaches to addressing health care costs and, therefore, reshaping their approaches.

A combination of variables was seen to be significant in Breaux, Duncan, Morris and Stanley's (2000) study of welfare benefits across the states. Though the economic well being of a state was an important factor in the level of cash assistance provided, it was in combination with a state's political culture that the best explanation of the variation of benefit levels could be viewed. The highest level of cash benefits were found in states that were both relatively wealthy and classified as moralistic while the lowest payments were observed in those states that were relatively poor and classified as traditionalistic.

Pressure groups

Grogan's study of the political and economic factors influencing state Medicaid policy (1994) highlighted the importance of interest groups in influencing decisions on distributive policies such as physician reimbursement rates. In this research, benefit structures will be of high interest to government employees, but likely rather insignificant to the general citizenry. Thus, they may be influenced in accordance with Grogan's pressure group model. Though Grogan's research on distributive policies was developed in the context of Medicaid benefits, not employee benefits, the researcher contends that the model can be utilized to test other state policies.

A potential source of pressure influencing benefit provisions could come from state employees' labor unions. Thirty-seven percent of state and local government employees are members of a union as compared to eight percent of private sector employees (McDonnell, 2005). Radcliff and Saiz (1998) analyzed the relationship between the liberalism of state's policies and union density and concluded that labor

organizations have a profound influence upon public policy. In Hayes and Kearney's (2001, p. 592) survey of public service human resource mangers referenced earlier, they found union impact on pay and benefits to be of primary importance to the practice of personnel management within union settings in 1998. The managers, however, did anticipate a decline in its relative priority by 2008 compared to other labor relations variables. Freeman (1986), in a review of ten earlier studies, found that public sector unions had a significantly greater impact on raising fringe benefits as compared to wages. The author went on to argue that, "politicians with short time horizons should be especially willing to negotiate contracts promising future fringes" (p. 58). This conclusion is supported by Moore's (1991) and McKethan, Gitterman, Feezer, & Enthoven's (2006) contention that unions, driven by the politics of public employment, may be more likely to press for benefit changes over pay increases to reduce the public visibility of the increases.

Unions have the potential of reducing state human resource managements' ability to negotiate favorable health insurance rates. As Hurley, Felland, Gerland, and Pickreign (2006) have pointed out, the unions' collective bargaining agreements prohibit major benefit changes except at renegotiation. The unions' ability to lock in benefits for extended periods of time reduces state governments' ability to renegotiate or change carriers when market conditions might indicate such action would be beneficial. Additionally, public employers frequently face multiple unions with staggered renewal dates, further limiting flexibility. Watts, Christianson, Heineccius, and Trude (2003) further elaborated on the difficulties arising when unions representing different workers demand distinct benefit packages. According to Maxwell, Temin, and Petigara (2004),

annual carrier contracts are the norm for Fortune 500 companies as opposed to 61% of state governments reporting contract periods of three or more years.

In a study of factors that accounted for variations across the states in various elements of state employee compensation, Kearney (2003) found that the higher the percentage of state employees belonging to a union, the lower the family health insurance cost of the premium. In fact, union density was the only statistically significant independent variable to impact family health insurance contributions. In Buchmueller, Dinardo, and Valletta's (2002) study of the union impact on provision and coverage of health insurance in the private sector between 1983 and 1997, they found union's impacting the take-up rate for insurance packages across all sizes of firms. They attributed this result to a likely increase in either the quality of the insurance or its cost to the employee.

The American Federation of State and County Municipal Employees (n.d.), the nation's largest public service employees union, cited health care as one of but three targeted areas listed for legislative action in 2006. In a resolution passed at their 2004 international convention, AFSCME called for a national single payer health care plan citing, "The most persistent challenges in bargaining are health costs and the erosion of health benefits; workers pay 50 percent more in cost sharing than they did 3 years ago, and insurance premiums are rising at double-digit figures for the third year in a row."

The largest union action in Minnesota's state government history occurred in 2001. According to Boulard (2004), 30,000 state government employees represented by two different unions went on strike for twenty-one weeks driven predominantly by the cost of health insurance and the portion for which the employees would be responsible.

In 2003, the union contract was readily signed when it came up again for negotiations. The quick resolution was attributed to the success of a multi-tiered insurance program that had been initiated allowing employees to choose health care providers at different price levels with corresponding differences in premium levels.

Political ideology, political culture, economic conditions, and the role of pressure groups will all be investigated to assess their potential impact on the variation between states' benefit structures.

How might we best investigate the issue?

If political ideology is thought to be a variable influencing the differing employee health care benefit structures between state governments how might we define and measure that ideology? Gerring has said, "Few concepts in the social science lexicon have occasioned so much discussion, so much disagreement, and so much self conscious discussion of the disagreement, as 'ideology'' (1997, p. 957). One possible methodology is a measurement tool designed by Berry, et al (1998) which incorporates such elements as the roll call voting scores of state congressional delegations, congressional election outcomes, the governor's party affiliation, the partisan split within state legislatures, and various assumptions pertaining to voters and state political elites. This method appears to be an expansion of one used by Buchanan, Cappelleri & Ohsfeklt (1991) that utilized Americans for Democratic Action and AFL-CIO's Committee on Political Education ratings of members of each state's congressional delegation. As further support for use of this methodology, Holbrook-Provow and Poe (1987) considered five means of measuring state political ideology and found roll call votes of state congressional delegations to be

preferable in terms of practicality and ease-of-use. Coffey (2005) finds favor in the Berry et.al. approach in terms of the ease of replicating the procedure, but criticizes the use of party as a proxy for the gubernatorial ideology. Burden, Caldeira, and Groseclose (2000) contend that roll-call based measures are as effective as alternative means in measuring ideology. Though they acknowledge that such measures can be influenced by the confounding effects of constituency and party, they maintain that these factors are overwhelmed by ideology. In contrast, they cite difficulty with measurements that rely on content analysis of press reports to determine ideology. The authors maintain that reporters, in a desire to focus on the unusual, tend to "exaggerate the conservative tendencies of southern Democrats" (p. 249) whereas ADA scores do not produce such a bias for southern Democrats and result in a high level of validity.

In another approach, Wright, Erikson, and McIver (1985) rely upon public opinion surveys to determine state partisanship and ideological composition. However, Brace, Arcenequx, Johnson, and Ulig (2004) in an assessment of the methodologies utilized by Berry, Ringquist, Fording, and Hanson (BRFH) versus Wright, Erikson, and McIver (WEM) see strengths in both. Their preference is clearly with WEM, but they see merit in utilizing BRFH's approach to measure elite preferences. For purposes of this research, it is the political elites that will formulate the policy decisions leading to the provision of health insurance benefits for state government employees.

Tools exist to measure differences in political ideology and economic conditions. Elazar (1966) classified each state into one of the three possible political cultures and information on public employee union membership across states is readily available. Examination of these variables across states will help us better understand what drives

the structure of benefit packages and whether the presence of certain variables may be more beneficial than others in the provision of a robust health insurance package for state government employees.

CHAPTER III

HYPOTHESES AND MEASUREMENT

As stated earlier, the purpose of this research is, first, to understand the variations in health care benefits provided to state government employees across all fifty states and, second, to determine what factors might contribute to such differences.

Hypotheses

The following figure is a graphic representation of the hypotheses to be tested and the formula for specifying the dependent variable; the specific nature of the hypotheses and the justification for the choice in measuring the dependent variable follow the visual presentation:

INDEPENDENT VARIABLES	DEPENDENT VARIABLE
State's Economic Condition ➔ *(Median family income)*	
Union Membership ➔ *(% of government employees union members)*	
	Level of Benefits
Degree of Liberalism ➔ *(ADA and AFL-CIO COPE federal ratings adjusted for state government)*	
Moralistic Political Culture ➔ *(Versus individualistic and traditionalistic)*	

Level of Benefits =

State government's contribution to employee family health care monthly premium

÷

Annual state's per capita health care expenditure

Annual national per capita health care expenditure

FIGURE 3.1

HYPOTHESES

H_1: There is a positive association between the level of benefits and the level of a state's economic condition.

H_2: There is a positive association between the level of benefits and the level of union membership of a state's government employees.

H_3: There is a positive association between the level of benefits and the degree of liberalism attributed to the state.

H_4: Variations in the level of benefits are explained by a state's political culture; moralistic states are more likely than traditionalistic or individualistic states to be associated with a higher level of benefits.

In each of the hypotheses, the level of benefits is the dependent variable determined by the independent variables of economic condition, size of union membership, degree of liberalism (political ideology), and moralistic political culture.

The rationale behind the development of the formula created to measure the dependent variable, level of benefits, is provided in the measurement section below. The hypotheses themselves evolved from a review of the literature. Ample evidence exists to indicate that tight economic times, combined with rising benefit costs, lead state governments to modify their offerings (Roberts 2001, Holahan et al 2004, Maxwell, Temin & Petigara 2004). Likewise, the literature supports unions' ability to influence the provision of employee benefits while potentially impeding state governments' ability to effectively negotiate favorable rates (Hayes & Kearney 2001, Freeman 1986, Hurley, Felland, Gerland & Pickreign 2006, Kearney 2003, Boulard 2004). This hypothesis assumes that the upward pressure on the provision of health care benefits exceeds any negative impact union contracts may have on states' negotiating ability. Political

ideology of elected officials has been shown to influence the development of public policy (Wright, Erikson & McIver 1989, Coggburn & Schneider 2003, Kingdon 2003) though the effect has not been studied in this particular context. As to political culture, states categorized as moralistic have been shown to provide either higher state expenditures on health programs or in support of public employee wages and benefits (Fitzpatrick & Hero 1988, Sharkansky 1978, Miller 1991, Koven & Mausolff 2002).

Measurement

Prior to testing the individual hypotheses, it is necessary to establish the level of variation in health care insurance benefits provided to state government employees across the selected states. The literature clearly establishes that the variation exists, so we need not hypothesize on its existence, but we need to understand the relative differences between the states to give meaning to the remainder of our research.

How to measure the variation of benefits across the states and how to define a "level of benefits" presents a conundrum. There is no established rating system. An attempt to assess all benefits and compare the value of such possible benefits as two chiropractic manipulations per year to one well-baby check-up runs the risk of being unwieldy and potentially subjective. A mere listing of benefits and count of services covered does little to inform us of the value of the insurance package to the employee.

A rational approach to assessing the variation and the level of benefit is to evaluate certain economic variables associated with the health care insurance. Though the total cost of the premium likely reflects both local health care costs and the bargaining strength of the state government in negotiating a rate, it is reasonable to

assume that the major factor influencing the premium is the value of services covered. Dollars and cents should, if properly analyzed, be a surrogate for available care.

Hypothetically, a formula that considered the total size of the monthly premium, the amounts paid by the employer and the employee, the amount of the deductible the employee is responsible for prior to first dollar coverage, applicable co-payments, and the per capita health care expenditure for all people (not just state government employees) in each state could produce a standardization for "level of benefits". The per capita expenditure would help mitigate against variations in health care costs across states. Such a formula does not, however, exist and the appropriate weighting of factors in developing such a formula is unknown.

A reasonable approach in measuring the level of benefits is to look at how much each state invests in its employees' health coverage (i.e. the state portion of the total monthly premium for each employee) and adjust that by some sort of per capita health care price index to allow for different prices for similar services across states. The decision to utilize the state portion versus the total premium was based on the thought that how much the state actually invests, adjusted for differences in health care costs across states, reflects the relative generosity of one state versus another. Therefore, I have operationalized the "level of benefits" as the state contribution to an employee's monthly health care premium for family coverage divided by the quotient of a state's per capita health care expenditure divided by the national per capita average health care expenditure. This approach is imperfect, but will serve as a reasonable proxy. Taking Mississippi as an example, the level of benefits would be computed as follows. The Mississippi state government contribution to the monthly family premium rate of $305

would be divided by .958. The divisor is the quotient resulting from dividing Mississippi's per capita health care expenditure of $5,059 by the national per capita health care expenditure of $5,283. The computation results in a level of benefit of $318.50. Appendix Table A.3 provides a state-by-state listing of all elements used to compute each state's level of benefits.

One potentially confounding variable not included in the hypotheses is the relative health of the states' government employees. Health status indicators do show that there are differences in the relative health of people across different states. If a state's population is healthier than another is it because they are investing more money in health care and getting better outcomes or might it be attributable to lifestyle and environmental differences, which actually reduce the need for many health care expenditures? The terms of that debate are beyond the scope of this research. However, an assessment of various health status indicators is provided in a later section to enhance understanding of the context within which the research results exist, and a proxy indicator for the health of all state residents subsequently is included as a control variable.

Related to the above potentially confounding variable is Gold and Ritchie's (1993) warning in observing their findings on a comparison of total fringe benefits between states. The researchers point out that the state's out-of-pocket expenses might vary differently from the variation seen in the rankings of provided benefits. For example, the age and family size of state employees will influence the actual costs incurred irrespective of the level of generosity assumed by the benefit package itself. Other factors potentially affecting a state's per capita health care expenditures are physician-to-

population ratio, local hospital capacity, and the disposition of states' residents to travel to other states for care (Martin, Whittle, Levit, Won, & Hinman, 2002).

The next variable to be operationalized is the economic condition of the state. Various measures could be used to impart meaning and rank order this variable. For our purposes, the states' median family income figure will be used. The mean individual per capita income was considered. It is the primary factor that the federal government utilizes in setting the state reimbursement rates for Medicaid insurance and therefore a seemingly suitable representation of economic conditions for this endeavor. The decision, however, to utilize the median family income was determined to be somewhat more relevant. The health insurance premiums included within the computation of the dependent variable are based upon family, not individual, premiums. Additionally, utilizing a median versus a mean income will protect against extremes at either end of the income spectrum.

Union membership will be defined as the percentage of each state's public employees who are union members. It was hoped to limit that data specifically to employees of state government; however, that subset of information could not be determined and the entire set of a state’s public employees holding union membership is a reasonable surrogate.

The next variable to be defined and measured is a state's political ideology. The ideology will be measured on a continuum from liberal to conservative. Previous researchers have developed varied methodologies to depict such ideologies. Berry et al (1998) have designed what appears to be a strong model for assessing the relative liberalism/conservatism of elected state officials. They explain and defend their

underlying assumptions, report on tests of reliability, and show evidence of construct validity. The model computes a weighted average of the ideology scores of the state's governor, Republican members of the state's two legislative bodies, and Democratic members of the state's two legislative bodies.

Determining state legislators' ideology is problematic since ratings assumed to be reliable do not exist across all states. Berry et al (1998) chose to utilize Americans for Democratic Action (ADA) and AFL-CIO Committee on Political Education (COPE) ratings for federal legislators and apply them to their party and legislative body counterparts on the state level; the governor's score was that of the estimated scores for the combined state legislators (house and senate) from the governor's party. As stated earlier, Berry et al's rating scheme for federal legislators is consistent with earlier work by Buchanan, Cappelleri & Ohsfeldt (1991).

Given the scores, weighted averages were applied to allow for differences in power. The researchers assumed equal power between the governor and the legislative branch, and equal power between the two chambers of the legislature. Further assumptions were made relative to the power equation for majority/minority status of the two dominant parties in each chamber.

The last variable to be measured is political culture. In describing the distribution of political cultures within the states, Elazar allowed for some intrastate variation; however, a dominant classification does exist for each of the states. Since his initial publication, some researchers such as Sharkansky have taken the original three classifications and established a 9-point schema that allows for the presence of a secondary subculture. This research will, however, utilize the original three primary

classifications: moralistic, traditionalistic, and individualistic. Given the limit of fifty observations, restricting the number of variables seems prudent.

Having defined the terms of the dissertation research and the specified measures, we can now turn to the actual gathering and assessment of the data.

Data collection and analysis

Data collection and analysis for this project will focus on quantitative methodologies. The four stated hypotheses will be subjected to quantitative analysis techniques.

The National Conference of State Legislatures (n.d.) has compiled data on a "standard benefits package" for state government employees in all fifty states for family health care coverage through an HMO from 1999-2006. The data was compiled by Workplace Economics, Washington D.C. and supplemented by state research and telephone interviews conducted by the National Conference of State Legislatures (NCSL). The state contribution for family coverage for plan year 2006 listed in the NCSL compilation serves as the state contribution to the employee health care premium in the level of benefits formula. The per capita health care expenditure figure for all people in each of the selected states, and for the country as a whole, was collected from data available on the Kaiser Foundation State Health Facts website (The Kaiser Family Foundation and Health Research and Education Trust, n.d.). The data is from 2004, the last year for which the Centers for Medicaid and Medicare Services have released data.

Next, the states' median family income was collected from the U.S. Census Bureau website (n.d.). The U.S. Census Bureau figures are from 2004-2005 and are

previous to the health care insurance data. Utilizing data from the previous year for the independent variables is based on the fact that policy decisions relative to a given year's employees' health insurance package would be made in the year preceding its availability. The Census Bureau derived its data from the Current Population Survey and applied an inflation-adjustment factor to the 2-year average median 2004-2005 income to reflect that income in 2006 dollars.

The union membership data is based upon the percent of public employees holding union membership in 2005. The data set was constructed by Hirsch & Macpherson (2008) and is based upon estimates derived from the Current Population Survey.

The government political ideology rating was obtained from a website maintained by R. Fording (n.d.), a co-author of the Berry, et al (1998) study containing the chosen measurement tool discussed above. The government ideology scores are computed on a scale of 1 to 100 with the most conservative states at the lowest range of the scale and the more liberal states at the higher end of the scale. The data retrieved was for the year 2005.

The classification of each state's political subculture was based upon the primary categorization for each state stipulated by Elazar (1984). Consideration was given to using the political culture scale developed by Sharkansky (1969) and expanded, to include Alaska and Hawaii by Koven and Mausolff (2002). Though this scale is more refined, and addresses Elazar's observation of blended cultures within a state, given the small sample size of fifty states it was determined to be more prudent to adhere to the three primary classifications. One potential draw back to the use of Sharkansky's scale is

that it results in the culture classifications looking like a continuum. As Wirt (1991) pointed out, Elazar saw them "more as sides of a triangle for which linear quantitative methods might be inapplicable" (p. 5). Additionally, Clynch (1972) has questioned both Sharkansky's conclusions and vigor in the construct of the researcher's scale.

Political culture was established as a dummy variable measured on whether the state was classified as having a moralistic political culture (coded as “1”) or as individualistic or traditionalistic in political culture (coded as “0”). The coding scheme reflects the specification of the hypotheses that a higher level of benefits is more likely associated with moralistic states than with traditional or individualistic states. This and the above information constitute the required elements of data collection.

To understand the relative contribution of each of the independent variables (economic condition, size of union membership, political ideology, and political culture) in explaining the dependent variable (the level of benefits) multiple regression analysis was conducted. Multiple regression allows us to see the independent effect of each of the independent variables on the level of benefits while controlling for the other variables in the equation. One problem that could arise is that of multicollinearity; the independent variables in the model may be redundant in their impact upon the level of benefits. However, given that we are limited to a sample size of 50 and that theory supports the model as constructed and does not present a rationale for combining variables, it will simply be necessary to test for the possibility and specify the results. In fact, Klingman and Lammers (1984, p. 603) saw a high correlation between states with a high moralistic culture as defined by the Elazar-Sharkansky index and their "general policy liberalism" factor.

If the research hypotheses are supported, a positive association should be found between the level of benefits and the state's economic condition (defined as the state's median family income), level of union membership of the state's government employees, and the degree of liberalism attributed to the state. Additionally, a variation should be seen between the level of benefits and the state's political culture with a greater likelihood of moralistic states to be associated with a higher level of benefits. Though an association was anticipated to be shown within each of the hypotheses, the strength of the association and the relative contribution of each factor were unclear. For any of the hypotheses to fail to show an association that, in and of itself, would be an interesting finding if it appears to be valid.

CHAPTER IV

DIMENSIONS OF VARIATIONS

Health status and health care is not equal across states. Before looking at the specific variables addressed by this dissertation, it is helpful to take a broad look at many of the underlying differences in health care and individual health standings between states. This will provide an enhanced context for the research and the implications of its findings. Variations in the quality and cost of health care as well as specific health status indicators all serve as underlying factors in the choice and price of health care plans for state governments. Additionally, some understanding of the types of health plans available to state employees as well as the considerations of state human resource directors will further our understanding of the environment. Finally, consideration should be paid to the possible relationship between choice of plans and a state's "generosity", be that the generosity of individual residents or as exhibited by government's support of health care.

Quality and cost

Recently, Cantor, Belloff, Schoen, How and McCarty (2007) developed a report for the Commonwealth Fund Commission on a high performance health system. The report focused on state-by-state variations in thirty-two indicators of five dimensions of

health system performance: access; quality; potentially avoidable use of hospitals and cost of care; equity (how well a state met the health care needs of its most vulnerable, the uninsured and low-income); and the ability to live long and healthy lives (p. 5). Key findings included (1) a wide variation of quality results across states, (2) recognition that leading states consistently outperformed lagging states, (3) a close association between better access and better quality, (4) analysis of state comparative data indicating that high quality is not associated with higher costs, and (5) recognition of substantial room for improvement for all states. Following, in FIGURE 4.1, is a chart indicating performance rankings of the states:

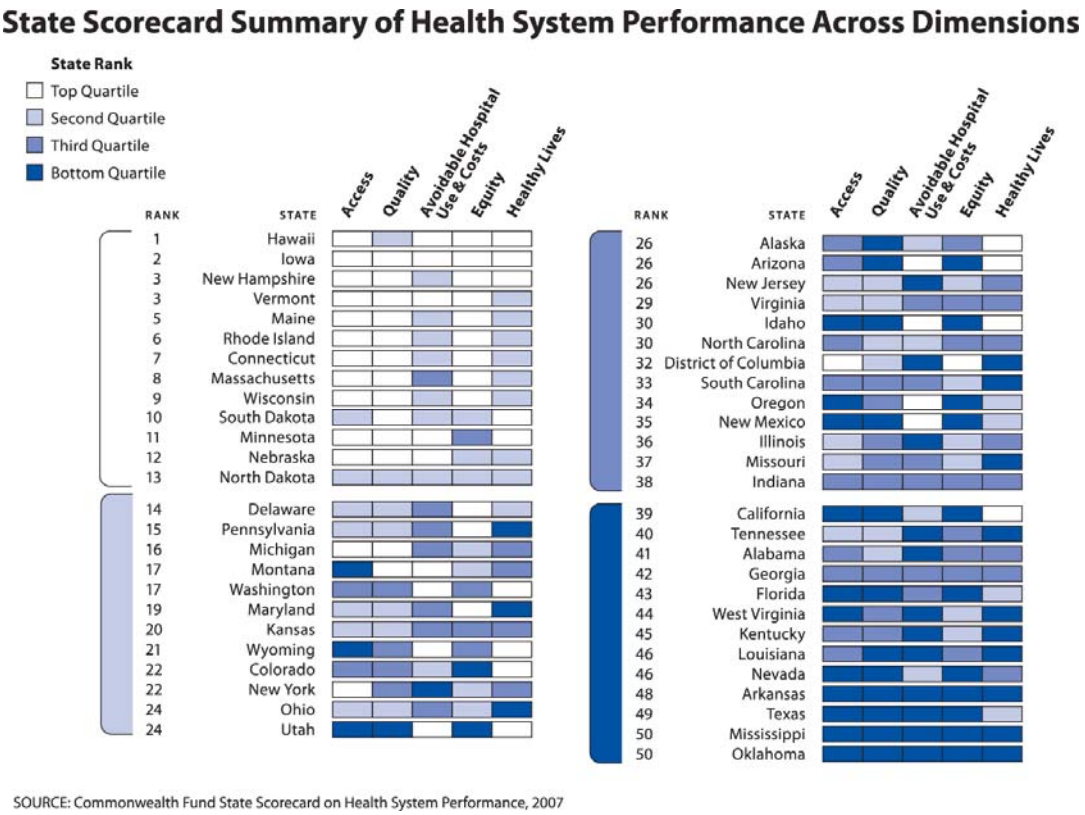

FIGURE 4.1

HEALTH SYSTEM PERFORMANCE

One example of the variation in quality of health care across states, as well as an indication of room for improvement, is the percentage of adults age fifty and older that receive recommended health screenings and preventive care. The researchers found a range of results from 32.6% - 50.1% receiving screenings and care with a median for all states of 39.7%. Though the researchers did not find a relationship between high cost and high quality, they did find a wide range in the average single premium per enrolled employees within private sector organizations offering health insurance. The range for cost of care varied from $3,034 - $4,379 with a median of $3,706 (p.6).

In operationalizing their research, Cantor et al. chose to use Medicare annual costs per beneficiary as the surrogate for cost of care. Other measures might not arrive at the same conclusion regarding the lack of relationship between high cost and high quality. In fact, of the twelve states (Iowa, New Hampshire, Vermont, Maine, Rhode Island, Connecticut, Massachusetts, Wisconsin, South Dakota, Minnesota, Nebraska, Michigan and Montana) classified in the top quartile for quality, all but Michigan exceed the national average per capita health care spending for 2004 as reported by Martin et al. (2007) and derived from the National Health Expenditures Accounts. Five of the twelve (Connecticut, Maine, Massachusetts, Rhode Island, and Vermont) exceed the national average by 15-27 %. The range of personal health care spending per capita for all states in 2004 was $3,972 (Utah) to $6,683 (Massachusetts), with a U.S. average of $5,283.

Differences in spending are frequently thought of as stemming from price differences. However, in a study of Medicare spending, Fisher (2006) found the most significant factor to be variations in volume and intensity of care. Looking at length of

hospital stays for seriously ill Medicare beneficiaries during their last six months of life, Fisher found:

> States in New England, the Midwest, the Mountain states and the Pacific Northwest had low rates compared to residents of Hawaii (16.4 days), New York (16.3 days) and New Jersey (15.2 days). Residents of Utah (7.3 days) and Oregon (7.8 days) had rates less than half the average among residents of New York and Hawaii. Utilization rates for other services, such as physician visits and the number of different physicians seen during the last six months of life, are highly correlated with hospital stays. (p.2)

Health status indicators

How best can we assess the level of health of residents of one state versus another? Two organizations, the United Health Foundation and Morgan Quitno Press, publish annual rankings of the healthiest states. United Health Foundation utilizes eighteen variables that characterize personal behaviors (e.g., prevalence of smoking), community environment (e.g. violent crime), public and health policies (e.g., lack of health insurance), health services (e.g., adequacy of prenatal care), and outcomes (e.g., premature death) in developing their rankings. Morgan Quitno's formula utilizes seventeen negative factors (e.g. smoking, obesity, teen births, lack of access to primary health care) and four positive factors (hospital beds, childhood immunization rates, adults who exercise regularly and safety belt usage). The rankings from both organizations can be found in TABLE 4.1 on the following pages.

By averaging the rankings for the two scales, the top ten healthiest states are Minnesota, Vermont, New Hampshire, Massachusetts, Hawaii, Maine, Utah, Connecticut, Iowa, and Nebraska. The ten least healthy states are Louisiana, Mississippi, South Carolina, Florida, New Mexico, Nevada, Tennessee, Alabama, Oklahoma, and

Arkansas. One notices the obvious concentration of "healthiest states" in the north and "least healthy" in the south. Though not a hypothesis of this dissertation, these rankings could be compared with Elazar's characterization of political culture within the states. The findings may prove of interest and stimulate subsequent research. The inclusion of various factors driven or influenced by government policy and actions may lead to some relationship with Elazar's classifications.

TABLE 4.1 STATE HEALTH RANKINGS, ALPHABETICAL BY STATE

State	*United Health Foundation 2006 America's Health Rankings*	*Morgan Quitno Press 2007 Healthiest State Award Rankings*	*Average of the two rankings*
Alabama	45	40	42.5
Alaska	31	36	33.5
Arizona	34	42	38
Arkansas	46	37	41.5
California	23	19	21
Colorado	16	28	22
Connecticut	5	13	9
Delaware	30	39	34.5
Florida	41	46	45
Georgia	42	44	43
Hawaii	4	9	6.5
Idaho	19	24	21.5
Illinois	25	32	28.5
Indiana	33	33	33
Iowa	11	7	9
Kansas	17	10	13.5
Kentucky	39	29	34
Louisiana	50	50	50
Maine	9	4	6.5
Maryland	32	35	33.5
Massachusetts	7	3	5
Michigan	27	21	24
Minnesota	1	2	1.5
Mississippi	49	48	48.5
Missouri	35	34	34.5

TABLE 4.1 Continued

State	*United Health Foundation 2006 America's Health Rankings*	*Morgan Quitno Press 2007 Healthiest State Award Rankings*	*Average of the two rankings*
Montana	22	26	24
Nebraska	12	6	9
Nevada	38	47	42.5
New Hampshire	3	5	4
New Jersey	14	16	15
New Mexico	40	49	44.5
New York	29	27	28
North Carolina	36	31	33.5
North Dakota	8	12	10
Ohio	25	20	22.5
Oklahoma	44	41	42.5
Oregon	19	17	18
Pennsylvania	28	23	25.5
Rhode Island	13	11	12
South Carolina	48	45	46.5
South Dakota	18	22	20
Tennessee	47	38	42.5
Texas	37	43	40
Utah	6	8	7
Vermont	2	1	1.5
Virginia	21	18	19.5
Washington	15	14	14.5
West Virginia	43	25	34
Wisconsin	10	15	12.5
Wyoming	23	30	26.5

Source: United Health Foundation, America's Health Rankings, 2006 ed. Morgan Quitno Press, Health Care State Rankings 2007

Though the United Health and Morgan Quitno (Morgan &Morgan) rankings are helpful in assessing the broad picture of the health of particular states, some factors in their equation are less meaningful when we are thinking about an employed population with access to employer provided health care. A more limited set of factors might prove more useful. Given that the Centers for Disease Control and Prevention (n.d.) estimate

that seventy percent of the nation's health care bill is attributable to chronic illness, risk factors for many chronic diseases such as obesity and smoking may help to inform us as to the health status variations of government employees in different states. The rankings for both risk factors can be found in TABLE 4.2 on the following pages.

Averaging the rankings for the two risk factors, the top ten healthiest states (defined as lowest average for obesity and smoking) would be Connecticut, Hawaii, Utah, Massachusetts, Vermont, California, Colorado, Montana, New Jersey, and Rhode Island. The ten least healthy states (defined as the highest average for obesity and smoking) would be West Virginia, Kentucky, Tennessee, Mississippi, Alabama, Indiana, Oklahoma, Arkansas, South Carolina, and Alaska. Again, we see the concentration of "healthiest states" in the north and "unhealthiest states" in the south.

TABLE 4.2 STATE OBESITY AND SMOKING RANKINGS

State	*Trust for America's Health 2007 Obesity Rankings**	*Kaiser Foundation Adult Smoking Rates***	*Average of the two rankings*
Alabama	3	7	5
Alaska	16	5	10.5
Arizona	42	30	36
Arkansas	8	10	9
California	36	49	42.5
Colorado	50	35	42.5
Connecticut	46	48	47
Delaware	29	25	27
Florida	34	19	26.5
Georgia	14	17	15.5
Hawaii	46	47	46.5
Idaho	31	44	37.5
Illinois	25	34	27.5
Indiana	9	2	5.5
Iowa	20	28	24
Kansas	27	45	36
Kentucky	7	1	4
Louisiana	4	14	18
Maine	33	23	28
Maryland	25	40	37.5
Massachusetts	49	42	45.1
Michigan	9	18	13.5
Minnesota	28	32	30
Mississippi	1	8	4.5
Missouri	12	11	11.5
Montana	44	39	41.5
Nebraska	18	22	20
Nevada	37	12	24.5
New Hampshire	38	29	33.5
New Jersey	40	43	41.5
New Mexico	41	20	30.5
New York	38	27	32.5
North Carolina	17	13	15
North Dakota	19	31	25

TABLE 4.2 Continued

State	*Trust for America's Health 2007 Obesity Rankings**	*Kaiser Foundation Adult Smoking Rates***	*Average of the 2 rankings*
Ohio	15	16	15.5
Oklahoma	9	6	7.5
Oregon	30	41	35.5
Pennsylvania	23	9	16
Rhode Island	45	37	41
South Carolina	5	15	10
South Dakota	20	36	28
Tennessee	5	3	4
Texas	12	33	22.5
Utah	43	50	46.5
Vermont	48	38	43
Virginia	23	26	24.5
Washington	31	46	38.5
West Virginia	2	4	3
Wisconsin	22	24	23
Wyoming	35	21	28

*Trust for Americas rankings are based upon the most obese state being #1; any difference from Trust for America's published health rankings is due to removal of the District of Columbia
**Kaiser provided data on percentage of adults smoking; the data has been converted to rank order with the state with the highest percentage of smokers ranked as #1.

Source: Trust for America's Health, *F as in Fat: How Obesity Policies Are Failing In America*
Kaiser State Health Facts

Interestingly, some of the "unhealthiest" states have begun to initiate changes in their health insurance plans to incent improved health habits of their employees. Alabama, one of the heaviest states in the nation, is initiating a plan to require a body mass index (BMI) screening of all employees. Those found to be obese by the BMI measurement in concert with high cholesterol, blood pressure, or blood glucose levels will have a year to reverse their condition. Failure to succeed will result in a monthly

increase of $25 in the employee portion of their health insurance premium (Fernandez, 2008).

Smoking surcharges have been added to the premiums of Alabama state employees as well. Other states that include smoking surcharges to their public employees include Kentucky, South Carolina, Georgia, Indiana, Kansas, and South Dakota. The monthly premium increases in these states range from $15 to $40 (CNNMoney, 2008)

Health plan choices and state generosity levels

As we begin to look at and analyze the differences between state employee health insurance plans it is important to recognize that the environment is far from static. Driven primarily by growing costs, states are looking for new solutions and innovations for providing health benefits. Silow-Carroll and Alteras (2007) have studied efforts initiated by the Massachusetts Group Insurance Commission (GIC), the Minnesota Smart Buy Alliance, and the Wisconsin Department of Employee Trust Funds in promoting value-driven health care for state government employees. New purchasing strategies are utilized which increase the accountability of providers for both the quality and costs of service. Additionally, employees are presented with economic choices structured to incent them to choose higher value providers and to engage in preventive health practices.

Minnesota's Department of Employee Relations (DOER), responsible for state government employees' health insurance purchases, has joined a coalition of other public as well as private insurance purchasers to form the Minnesota Smart Buy Alliance. The

Alliance represents about sixty percent of state residents allowing for considerable negotiating leverage. As a result of incentive-based strategies and a disease management focus, DOER was able to hold premiums steady with no increase in 2006 and recognize a $20 million savings that was returned to state employees through a "premium holiday."

Wisconsin's Employee Trust Fund Pharmacy Benefit Manager receives a bonus if the state saves money. That incentive combined with a three-tier evidence-based formulary and additional quality and efficiency methods have resulted in an estimated savings of $160 million across three years.

Massachusetts GIC, covering more than 285,000 state employees, retirees, and their dependents, requires their health plans to initiate tiered cost sharing plans. Current designs include placing hospitals and group physician practices into tiers. Within three years all plans will be required to place individual physicians into tiers. One challenge in this approach is the frequent consumer assumption that higher priced providers are inherently better. Tiering based on quality will likely go through a number of hurdles in both establishing "quality" and in gaining the desired consumer response.

In a related attempt to control costs and increase quality, CalPers, the California Public Employees Retirement System, has initiated a plan that restricts HMO participating hospitals and medical groups to those that achieve required cost and quality improvements (McKethan et al., 2006). Should a hospital or medical group be removed from the HMO, employees that choose to continue using these providers may do so by enrolling in another plan that retains the provider, but at an increased cost to the employee.

Though such practices as tiered pricing and alternative plans may present some confusion, and certainly necessitate some investigation, studies (Davis, Collins, Schoen, & Morris, 1995; Ullman, Hill, Scheye, & Spoeri, 1997; Rice, Gabel, Levitt & Hawkins, 2002) have shown that being offered a choice of plans has a strong correlation with employee satisfaction with their health care benefits. Rice, et al., reporting on findings from a Kaiser Foundation study, found that seventy-two percent of governmental organizations, as compared to a national average of sixty percent, offered employees a choice in health care plans.

What type of health plans are currently offered by state governments? In a 2005 survey of state human resource directors, Reddick and Coggburn (2007) identified five primary types of health plan offerings: conventional, health maintenance organizations (HMO), preferred provider organizations (PPO), point-of-service (POS), and high deductible health plans (HDHP). Conventional plans are the traditional fee-for-service plans that dominated the health insurance market place until escalating costs drove development of new and competing offerings. HMOs restrict participants to a particular set of physicians and health care facilities. PPOs incent plan members by offering lower deductibles and co-payments to utilize designated physicians and hospitals, but members are not restricted from using out-of-network providers. POS plans operate in a manner similar to an HMO; however, with the approval of their in-network plan primary care physician, members can seek care outside of the network at a lower reimbursement rate. HDHPs are characterized by lower premiums and higher deductibles and are generally associated with health savings accounts (HSA) allowing individuals to establish tax-deferred accounts for future possible medical expenses. TABLE 4.3 below provides plan

availability information obtained from the eighty percent of state human resource directors responding to Reddick and Coggburn's survey.

TABLE 4.3 TYPES OF STATE EMPLOYEE HEALTH PLANS OFFERED

	Percentage of responding states offering plan	*Percentage of responding states not offering plan*	*Percentage enrollment*	*Average number of type plan offered by state governments*
Conventional	27.5	72.5	18.0	.8
HMO	73.7	26.3	39.0	3.1
PPO	87.5	12.5	56.6	1.8
POS	25.6	74.4	13.5	.6
HDHP	30.8	69.2	NA	NA

Source: Reddick and Coggburn, 2007 (p.12)

Reddick and Coggburn asked the human resources directors about the factors that influenced their choice of health plans for state employees. The directors' responses are provided in TABLE 4.4 below. Interestingly, the majority of respondents cited union and/or collective bargaining as not too or not at all influential. In fact, it was the lowest rated of the seven listed factors affecting choice. This contrasts with Hayes and Kearney's (2001) survey of public service human resource mangers referenced in the literature review. In those surveys, conducted in 1998, union impact on pay and benefits was found to be of primary importance to the practice of personnel management within union settings. The disparity in results might be due to a possible decline in union influence and size of membership over time. Perhaps union influence was stronger amongst the 20% non-respondents to Reddick and Coggburn's study, thus masking the degree of influence.

TABLE 4.4 FACTORS THAT AFFECT CHOICE OF HEALTH PLANS

	Very Influential	*Somewhat Influential*	*Not too Influential*	*Not at all Influential*	*Don't know*
Cost to state government	80.0%	20.0%	0	0	0
Access to care (e.g., location, hours, breadth of network)	69.2%	28.2%	0	2.6%	0
Cost to employee	65.0%	27.5%	2.5%	5.0%	0
Quality of physicians (e.g., the percentage board certified)	47.4%	44.7%	5.3%	2.6%	0
Customer service and/or administration by the plan	45.0%	52.5%	0	0	0
Accreditation status and rating	30.8%	48.7%	17.9%	0	2.6%
Union and/or collective bargaining	25.6%	12.8%	15.4%	46.2%	0

Source: Reddick and Coggburn, 2007 (p.15)

If cost is in fact the largest factor influencing health plan choice, might different states respond differently to cost? Might some states be more generous than others? The Catalogue for Philanthropy (n.d.) publishes an annual generosity index based upon individual levels of giving compared to income. The information comes from Internal Revenue Service personal income tax returns utilizing average adjusted gross income and average itemized charitable donations. By comparing the rank orders of each state's average adjusted gross income with its average itemized charitable deduction and rank ordering the differences between the two measurements, they arrive at a national ranking of generosity for the fifty states. The results for 2005 (based upon 2003 IRS filings) are presented in TABLE 4.5 below. Having produced the index since 1997, the organization is cognizant of its critics, but responds that although the Internal Revenue Service data

may not be ideal, it is the only data easily available on an annual basis that provides both income and charitable giving amounts. Further, they contend that eighty percent of all personal giving is captured in itemized charitable deduction reporting. Their findings indicate “that nationwide, giving is not consistently related to income; rather, giving is shaped more by cultures, which tend to be regional, and by religion (not politics)”. Eight of the top ranked states are located in the south.

TABLE 4.5 NATIONAL GENEROSITY INDEX, 2005

State	*Adjusted Gross Income Rank*	*Itemized Charitable Deduction Rank*	*Rank Relation*	*Generosity Index*
Mississippi	50	6	44	1
Arkansas	46	5	41	2
South Dakota	44	9	35	3
Oklahoma	42	8	34	4
Tennessee	35	3	32	5
Alabama	38	7	31	6
Louisiana	43	12	31	7
Utah	30	2	28	8
South Carolina	39	13	26	9
West Virginia	48	22	26	10
Idaho	41	20	21	11
Texas	22	4	18	12
Nebraska	34	17	17	13
North Dakota	45	29	16	14
Wyoming	17	1	16	15
North Carolina	28	16	12	16
Kansas	27	15	12	17
Florida	23	14	9	18
Georgia	18	11	7	19
Missouri	31	24	7	20
Kentucky	40	33	7	21
New Mexico	47	40	7	22
Montana	49	45	4	23
Indiana	29	31	-2	24
Alaska	25	28	-3	25

TABLE 4.5 Continued

State	*Adjusted Gross Income Rank*	*Itemized Charitable Deduction Rank*	*Rank Relation*	*Generosity Index*
New York	5	10	-5	26
Iowa	36	42	-6	27
Nevada	13	21	-8	28
Ohio	32	44	-12	29
Maine	37	49	-12	30
California	6	19	-13	31
Maryland	4	18	-14	32
Washington	11	25	-14	33
Vermont	33	47	-14	34
Oregon	26	41	-15	35
Pennsylvania	19	34	-15	36
Virginia	7	23	-16	37
Arizona	21	37	-16	38
Delaware	14	30	-16	39
Illinois	9	26	-17	40
Michigan	16	35	-19	41
Hawaii	24	43	-19	42
Colorado	10	32	-22	43
Minnesota	12	36	-24	44
Connecticut	1	27	-26	45
Wisconsin	20	46	-26	46
Rhode Island	15	50	-35	47
New Jersey	2	38	-36	48
Massachusetts	3	39	-36	49
New Hampshire	8	48	-40	50

Source: Catalogue for Philanthropy (n.d.)

If the Catalogue for Philanthropy's assumption that generosity is driven by the culture of an area is valid, then perhaps individual generosity might translate to governmental generosity. One feasible way of assessing a state government's level of generosity relevant to health care is to look at the government's total health care expenditures (employee health insurance, Medicaid, public health, community health centers, etc.) as a percent of the state's gross state product (GSP). Such a comparison can be found in TABLE 4.6 below. In this comparison we see greater geographic dispersion than observed earlier. Rather than a clustering of southern states in the top ranks of spending as a percent of GSP, the southern states are distributed throughout the list from the highest ranked to one less than the lowest ranked of the states.

TABLE 4.6 TOTAL STATE GOVERNMENT HEALTH EXPENDITURE AS PERCENT OF THE GROSS STATE PRODUCT, 2003

Rank	***State***	***State Government Health Spending as % GSP***
	United States	3.3%
1	Mississippi	5.9%
2	Maine	5.3%
3	New York	5.3%
4	West Virginia	4.9%
5	Rhode Island	4.8%
6	Hawaii	4.5%
7	Louisiana	4.3%
8	South Carolina	4.3%
9	New Mexico	4.3%
10	Pennsylvania	4.3%
11	Vermont	4.1%
12	Arkansas	4.1%
13	Kentucky	4.0%
14	Tennessee	4.0%
15	Missouri	3.9%
16	Alaska	3.9%
17	Alabama	3.8%
18	Montana	3.7%
19	North Dakota	3.5%
20	North Carolina	3.4%
21	Georgia	3.4%
22	Minnesota	3.3%
23	Nebraska	3.3%
24	Ohio	3.3%
25	Oklahoma	3.3%

TABLE 4.6 Continued

Rank	*State*	*State Government Health Spending as % GSP*
26	New Jersey	3.3%
27	Wyoming	3.2%
28	Washington	3.2%
29	Maryland	3.2%
30	Michigan	3.2%
31	Oregon	3.2%
32	Connecticut	3.1%
33	Texas	3.1%
34	Arizona	3.0%
35	Kansas	3.0%
36	Idaho	2.9%
37	New Hampshire	2.8%
38	South Dakota	2.8%
39	Delaware	2.8%
40	Florida	2.8%
41	California	2.7%
42	Wisconsin	2.7%
43	Iowa	2.7%
44	Massachusetts	2.6%
45	Illinois	2.6%
46	Indiana	2.5%
47	Utah	2.0%
48	Nevada	1.9%
49	Virginia	1.8%
50	Colorado	1.8%

Notes: Includes state-funded health care expenditures for Medicaid, the State Children's Health Insurance Program, state employees" health benefits, corrections, higher education, insurance and access expansion, public health-related expenditures, state facility-based services, and community-based services. Sources of state expenditures include general funds, other state funds, and federal funds. Percentage based upon the total state gross product as cited by the Bureau of Economic Analysis in June, 2003.

Source: Kaiser State Health Facts

Significant variation does exist across the states in the quality and cost of health care, in the health status of the residents of each state, and in the resources we seem willing to apply in support of health. As we have seen, health system performance and the health status of individuals appear to favor the northern versus the southern states. This division is not, however, replicated when we look at the percent of the gross state product each state applies to governmental health expenditures. No clear geographic pattern emerges from this measure and, interestingly, only two of the states in the top quartile of spending as a percentage of the GSP are classified as moralistic states.

Variation likewise exists in the type of health plans offered to state workers, though preferred provider organizations (PPO) and health maintenance organizations (HMO) are offered by the greatest percentage of states. With cost being cited as the most significant factor in a state's choice of plans they do, however, appear to be attempting to provide a variety of options to employees. Rather than limiting choice, attention is paid to incenting employees to choose plans and providers representing higher value.

A backdrop of variety in plans, expenditures, health systems, and health outcomes exists across the country. Next we will look at the results of the hypothesized associations between the level of health care benefits provided to state government employees and factors that might influence those levels.

CHAPTER V

RESULTS

Descriptives

First, let us look at the basic descriptive statistics associated with the variables of interest. The dependent variable, level of benefit (defined as the state government's contribution to an employee's monthly family health care premium divided by the quotient of the state's per capita health care expenditure divided by the national per capita health care expenditure), showed a wide range in the value of the benefit from a low of $318.50 in Mississippi to a high of $1834.47 in New Hampshire, with a mean value of $809.04 (see Appendix A).

Wide fluctuations are seen in the range of many of the component elements of the level of benefit variable. The annual state per capita health care expenditures ranged from $3,972 in Utah to Massachusetts' $6,683; the national per capita expenditure was $5,283. States varied in the proportion of the family's total health care premium they funded, ranging from 38.1% (North Carolina) to 100% (New Hampshire, New Jersey, North Dakota, Oklahoma and Oregon); the mean proportion funded was 79.8%. The actual dollar amount funded by the states of each family's monthly premium averaged $819 with a range of $305 in Mississippi to $1,886 in New Hampshire.

As to the independent variables, the state's economic condition, measured as the median family income, ranged from $35,525 in Mississippi to $62,223 in New Jersey with a mean of $47,635 (see Appendix B). The percentage of public employees within a state holding union membership varied from a low of 7.4% in South Carolina to a high of 68.9% in New York; the average union membership was 32.87% across all states (see Appendix C). On a scale of 1-100 with 1 being the most conservative and 100 the most liberal of states, the government ideology variable ranged from 10.13 in Utah to 91.99 in New Mexico with the average score hovering toward the middle at 49.93 (see Appendix D). Elazar distributed the classification of political cultures fairly equally across the states. Seventeen states were classified as moralistic; the remaining thirty–three states were divided into seventeen individualistic and sixteen traditionalistic political cultures (see Appendix E).

TABLE 5.1 below is a table of the descriptive statistics associated with the variables of interest:

TABLE 5.1 DESCRIPTIVE STATISTICS FOR VARIABLES OF INTEREST

Variable	*Minimum*	*Maximum*	*Mean*	*Standard Deviation*	*N*
Level of Benefit (Dependent variable)	$318.50 (monthly)	$1834.47 (monthly)	$809.04 (monthly)	$271.97 (monthly)	50
Median family income (annual)	$35,525	$62,223	$47,635	$7,081.73	50
Union membership	7.4%	68.9%	32.87%	17.94%	50
Government ideology	10.13	91.99	49.94	26.74	50
Moralistic political culture*	0	1	.34	.479	50

*Political culture is a dummy variable measured on whether the state was classified as having a moralistic political culture (coded as "1") or as individualistic or traditionalistic in political culture (coded as "0").

Appendices A-E provide the state by state values for each of the variables.

Correlations

Now, let us begin to look at the specific hypotheses of this dissertation. H_1 stated, "There is a positive association between the level of benefits and the level of a state's economic condition." Bivariate correlation analysis was performed and established a

positive association between the two variables that was statistically significant at the .01 level. A Pearson correlation of .353 was rendered as a measurement of the strength of the relationship between the level of benefits and the level of a state's economic condition (measured as the state's family median income). Pearson's correlation is a quantitative measure of the strength of the linear relationship between two variables. As O'Sullivan, Rassel & Berner (2003) have stated, there is not a definitive answer to how large a correlation coefficient need be to merit attention. Though values of .4 to .6 frequently seem quite strong in the social sciences, more modest results may well be worthy of investigation.

As was explained in Chapter III, the median family income was selected as the measure for this variable due to its similarity with the personal per capita income measure used by the federal government in determining state Medicaid reimbursement rates. An alternative measure, the state Gross Domestic Product (GDP) was also considered; however, analysis failed to indicate a statistically significant association between the dependent variable, level of benefit, and the state GDP measure. Neither did it provide for a statistically significant model when later incorporated into the regression model.

Next, a positive association was shown in H_2 which stated, "There is a positive association between the level of benefits and the level of union membership of a state's government employees." A Pearson's correlation of .317 was rendered from this bivariate correlation analysis. The association was found to be statistically significant at the .05 level.

Analysis failed to establish a statistically significant measure of association for H_3, "There is a positive association between the level of benefits and the degree of liberalism attributed to the states."

Finally, H_4, "Variations in the level of benefits are explained by a state's political culture; moralistic states are more likely than traditionalistic or individualistic states to be associated with a higher level of benefits," rendered a Pearson's correlation of .259 and was found to be statistically significant at the .05 level.

TABLE 5.2 below is a table of findings:

TABLE 5.2 MEASURE OF ASSOCIATION TO THE DEPENDENT VARIABLE, LEVEL OF BENEFITS

Independent Variable	*Pearson's correlation*	*Significance (1-tailed)*	*N*
Median family income	.353	.006	50
Union membership	.317	.013	50
Government ideology	.091	.265	50
Moralistic political culture	.259	.035	50

Given the results, we reject the null hypotheses for H_1, H_2 and H_4 and have insufficient information to reject the null hypothesis for H_3. In other words, three of my four hypotheses receive evidential support. Even for the fourth hypotheses, government ideology, the direction of the relationship is in the hypothesized direction.

Multiple regression

Having analyzed the relationship between the dependent variable and each of the independent variables in isolation, the next step is to look at the combined effect of the variables and perform multiple regression analysis. This will enable us to determine if, and how much, the independent variables are likely to predict the value of the dependent variable.

Model 1

The first model is structured upon the following formula:

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \varepsilon$$

Y represents the dependent variable, the level of benefits; β_0 represents the intercept; β_1 through β_4 represent the slopes of each of the independent variables; X_1 represents the state's median family income; X_2 represents the percentage of union membership amongst a state's public employees; X_3 represents government ideology; X_4 represents moralistic political culture; and ε represents the error variable.

The model demonstrated that 18.7% (the unadjusted R^2) of the variation in the level of benefits is explained by the independent variables specified in the model, but none of the independent variables were found to be statistically significant. Median family income neared statistical significance at a p-value of .077 as did a moralistic political culture with a p-value of .067. However, the model as a whole was valid as indicated by the F-test (F=2.583 and p-value = .050).

If the regression coefficients that are not statistically significant are interpreted as the population coefficients, then, any increase in a state's median family income

corresponds to an expected $9 increase in the monthly level of benefits for a $1,000 increase in median family income controlling for all other variables in the model. Further, for each percentage increase in a states' union membership, there is a corresponding increase of $2.15 in the level of benefits, for each unit increase in the liberal ranking of a state there is a corresponding increase of $.04 in the state's level of benefits, and states with a moralistic political culture have a level of benefit averaging $120.75 higher than non-moralistic states while controlling for all other variables in the model.

Tests for multicollinearity were conducted to determine if any of the independent variables were redundant in their impact upon the dependent variable. All tolerances were greater than .25 and all variance inflation factors (VIFs) were less than 4; therefore, according to Netter and Washerman (R. Travis, class communication, March 25, 2004), no significant multicollinearity was identified between the independent variables. Interestingly, however, when viewed separately from the dependent variable, there was a statistically significant correlation between union membership and government ideology and between union membership and median family income. The results of that analysis are shown in TABLE 5.3 below.

TABLE 5.3 CORRELATIONS AMONGST INDEPENDENT VARIABLES

		MedInc	*UnMem*	*GovIdeol*	*Moralistic Pol Cult*
MedInc	Pearson Correlation	1	.590(**)	.092	.112
	Sig. (1-tailed)		.000	.263	.220
	N	50	50	50	50
UnMem	Pearson Correlation	.590(**)	1	.378(**)	.136
	Sig. (1-tailed)	.000		.003	.174
	N	50	50	50	50
GovIdeol	Pearson Correlation	.092	.378(**)	1	.051
	Sig. (1-tailed)	.263	.003		.362
	N	50	50	50	50
Moralistic Pol Cult	Pearson Correlation	.112	.136	.051	1
	Sig. (1-tailed)	.220	.174	.362	
	N	50	50	50	50

** Correlation is significant at the 0.01 level (1-tailed).

A review of the standardized regression coefficients allows us to assess the relative importance of the four independent variables. With a beta weight of .245, median family income is ranked as the most important variable in the model, followed by a moralistic political culture (.212), union membership (.142). and, finally, government ideology (.004). However, since none of these four variables proved to be statistically significant in the model, the attribution may simply be an artifact of the sample. Though, if viewed as population data, statistical significance is less critical. Results of the model are presented in TABLE 5.4 below.

TABLE 5.4 RESULTS OF MULTIPLE REGRESSION ANALYSIS FOR MODEL 1

Variable	*Regression Coefficient*	*Standard Error*	*Standardized coefficient*	*t – statistic*	*Significance p-value (one-sided)*	*Tol-er-ance*	*VIF*
Constant	247.251	282.472		.875	.193		
Median family income	.009	.007	.245	1.447	.077	.631	1.585
Union membership	2.150	2.766	.142	.777	.220	.543	1.842
Government ideology	.040	1.500	.004	.027	.489	.831	1.204
Moralistic political culture	120.751	77.184	.212	1.564	.067	.980	1.020
R^2	.187						
Adjusted R^2	.114						
F	2.583 (p-value=.050)						

The dependent variable is the level of benefits

Outliers

In order to detect possible outliers influencing the results, Cook's D, studentized residuals and hat-values were assessed. The studentized residual identifies extreme cases in the dependent variable based upon the difference in its observed versus predicted value. Both New Hampshire and Oklahoma exceeded Fox's (1991) recommended cutoff of ±2 standard deviations when assessing the studentized residual (New Hampshire 3.29640, Oklahoma 2.06941). New Hampshire did have the highest level of benefit of all

the states, however, Oklahoma was not unusually high. Additionally, the computed Cook's D value for New Hampshire exceeded Chatterjee and Hadi's (1988) suggested cutoff of $D_i > 4/(n-k-1)$ by .27 (.27235 computed Cook's D vs. suggested cutoff of .09). The Cook's D measure assesses a combination of the dependent and independent variables. Finally, the hat-value measure assesses values that have the largest impact based upon a combination of independent variable values. New York and Utah both exceeded the suggested cutoff point (computed as .15998) associated with the hat values measurement; New York's value was .18054 and Utah's was .1641. Though based on the combination of independent variable values, recall that New York had the highest percent union membership of the fifty states and Utah had the most conservative government ideology score of the fifty states.

Atypical data can be problematic and consideration should be given to discarding unusually high or low values. However, when the discrepant data-point is correct, as is the case with the above states, they may add value to our understanding. Automatic deletion of outliers may not be appropriate. In this instance an alternative model was analyzed without New Hampshire given that it was identified by two of the measurement tools. The analysis was performed to assess if the deletion might provide greater insight by substantively changing results. Following, in Table 5.5, is the result of that model as contrasted with the originally specified model:

TABLE 5.5 MULTIPLE REGRESSION ANALYSIS WITH AND WITHOUT OUTLIERS

	R^2	*Adjusted* R^2	*F-ratio*	*p-value*	*Significance of independent variables (one-sided)*
Model 1 (all 50 states)	.187	.114	2.583	.050	Median family income (.077) Union membership (.220) Government ideology (.489) Moralistic (.067)
Model 2 (without New Hampshire)	.124	.044	1.553	.204	Median family income (.190) Union membership (.184) Government ideology (.421) Moralistic (.144)

The dependent variable is the level of benefits

Deletion of New Hampshire weakened the strength of the originally suggested model. Given that the data are correct, and that there is no theoretical reason to delete a state, New Hampshire was left within the specified model.

Alternative models

Another scenario worthy of investigation was to delete individual independent variables from the regression. As was indicated above, though no significant multicollinearity was detected, when viewed separately from the dependent variable, there was a statistically significant correlation between union membership and government ideology and between union membership and median family income. Therefore, each of those variables was separately deleted from Model 1. Following is a table indicating the impact on Model 1 when separately deleting median family income, union membership and government ideology:

TABLE 5.6 REMOVAL OF INDEPENDENT VARIABLES, RESULTANT p-VALUES (ONE-SIDED)

Variable	*Model 1 All Variables*	*Model 1 Without Median Family Income*	*Model 1 Without Union Membership*	*Model 1 Without Government Ideology*
Median family income	.077	-	.010	.072
Union membership	.220	.024	-	.194
Government ideology	.489	.410	.356	-
Moralistic political culture	.067	.057	.054	.060
R^2	.187	.149	.176	.187
Adjusted R^2	.114	.093	.122	.134
F-ratio	2.583 (p-value = .050)	2.683 (p-value = .058)	3.271 (p-value = .029)	3.521 (p-value = .022)

The dependent variable is the level of benefits

Deleting factors simply did little to strengthen the originally hypothesized model. It did, however, in some instances, raise individual variables to the level of statistical significance. Union membership becomes statistically significant with the deletion of median family income. The median family income becomes statistically significant with the deletion of union membership. The deletion of median family income and the deletion of union membership each result in a slight increase of the p-value associated with moralistic political culture, though not to the level of statistical significance. The changes detected in the analyses in Table 5.6 do not, however, merit wavering from the original model. The changes were small and the original hypotheses were theoretically sound.

The next scenario that was considered addressed differences in political culture. The reference culture throughout the analysis to this point had been a moralistic culture. Is there something to be learned by modifying the independent variable to establish either a traditionalistic or individualistic culture as the reference culture? Was, perhaps, a combination of cultures informative? As above, the analysis was conducted utilizing all fifty states as in Model 1. Changing the reference culture to Individualistic minimally strengthened the model raising the adjusted R^2 from .114 to .120 and remained statistically significant at the .05 level. Within the individualistic model, the median family income variable rose to the level of statistical significance. None of the other models were found to be statistically significant. Following is a table of the results:

TABLE 5.7 MULTIPLE REGRESSION ANALYSIS VARYING COMBINATIONS OF POLITICAL CULTURES AS REFERENCE CULTURE

	R^2	*Adjusted* R^2	*F-ratio*	*p-value*	*Significance of independent variables (one-sided)*
Model One – Reference Culture, Moralistic	.187	.114	2.583	.050	Median family income (.077), Union membership (.220), Government ideology (.489), Moralistic (.067)
Alternative Model Two – Reference Culture, Traditionalistic	.144	.068	1.887	.129	Median family income (.097), Union membership (.254), Government ideology (.465), Traditionalistic (.404)
Alternative Model Three – Reference Culture, Individualistic	.191	.120	2.663	.045	Median family income (.035), Union membership (.085), Government ideology (.393), Individualistic (.053)
Alternative Model Four – Reference Culture, Moralistic and Traditionalistic	.197	.106	2.160	.076	Median family income (.057), Union membership (.151), Government ideology (.434), Moralistic (.047), Traditionalistic (.228)
Alternative Model Five – Reference Culture, Moralistic and Individualistic	.197	.106	2.160	.076	Median family income (.057), Union membership (.151), Government ideology (434), Moralistic (.289), Individualistic (.228)
Alternative Model Six – Reference Culture, Traditionalistic and Individualistic	.197	.106	2.160	.076	Median family income (.057), Union membership (.151), Government ideology (.434), Traditionalistic (.289), Individualistic (.047)

The dependent variable is the level of benefits

Again, it was determined to be inappropriate to change the model based upon these results. The improvement shown by the individualistic model was minimal at best.

The concluding scenario, utilizing the hypothesized variables, allowed for the substitution of Elazar's three classifications of political culture with Sharkansky's nine-point schema. Sharkansky's scale was based upon Elazar's identification of secondary subcultures within a state. Elazar was unable to identify the intrastate variations in Alaska and, therefore, Sharkansky did not include the state in his work. Consequently, my analysis, utilizing the Sharkansky scale, did not incorporate Alaska. This model did result in a slightly higher unadjusted R^2 than the previously chosen model. Utilizing the Sharkansky scale, 21.1% of the variation in the level of benefits could be explained by the independent variables in the model as opposed to 18.7% in the chosen model. However, the increase did not seem sufficiently large to justify substituting the scale since a state, Alaska, would have to be eliminated from the analysis. As was true in the earlier model, none of the independent variables were statistically significant, though the model itself was significant at the .05 level.

The correlation analysis did show an increased strength of association between the dependent variable, level of benefits, and the independent variables when utilizing the Sharkansky scale. As in the previous analysis, the association with government ideology failed to reach a level of statistical significance. Following are the results:

TABLE 5.8 MEASURE OF ASSOCIATION TO THE DEPENDENT VARIABLE, LEVEL OF BENEFITS, UTILIZING SHARKANSKY'S SCALE WITH THE ELIMINATION OF ALASKA

Independent Variable	*Pearson's correlation*	*Significance (1-tailed)*	*N*
Median family income	.385	.003	49
Union membership	.333	.010	49
Government ideology	.073	.308	49
Sharkansky scale of political culture	-.386	.003	40

By way of explanation, the negative correlation for Sharkansky's scale of political culture with the level of benefits is due to reverse coding. A moralistic culture is at the bottom of the nine-point scale. The strength of the association is not affected since that is based upon the absolute value of the Pearson's correlation.

Control variables

Might other variables, beyond those specified in the hypotheses, influence the level of benefits and what might they be? Earlier, in Chapter IV, contributors to chronic illnesses such as obesity and smoking rates, as well as the general health status of the people within a state, were discussed and variances between states were identified; these might be relevant factors. An association might exist between how well a state is perceived to perform an array of human resource management functions and the benefits provided to its employees. The age of the state workforce might influence both the cost of providing benefits and the interest in a strong benefit package. Race, average family

size, percentage of women in the state government workforce are additional factors that might impact the level of benefits.

Health status indicators, government performance measures, and the age of the state government workforce were all selected to be used as control variables. Though race, average family size, and percentage of women in the state government workforce were considered worthy of investigation, the data for these attributes could not be found on a state-by-state basis and, therefore, that analysis was not performed.

Below is a description of how each of the new variables was measured, the descriptive statistics found to be associated with each, the correlation between the dependent variable and these newly established control variables, and, finally, the impact of adding these variables into the regression analysis.

Measurement and descriptives

First let us look at a measure of health status that might be applied to the state government workers. Information pertaining to the health of each state's total population is available, though not solely for government employees. Chapter IV argued that contributors to chronic illnesses might prove to be a more useful tool in assessing possible health status variations of government employees rather than the broader picture offered by the United Health Foundation and Morgan Quitno Press annual rankings of healthiest states. The healthiest state rankings incorporate such items as percent of uninsured within a state, teen birth and high school graduation rates; these and other factors are less meaningful when thinking about an adult, employed population with access to employer provided health care. It was decided, however, to first assess the

contributors to chronic illness, operationalized as the average of the obesity and adult smoking rankings for each state, as a control variable and later substitute that variable with the healthiest state rankings to see if there was a different outcome based upon the selected measure. In both instances the data utilized was from 2005 to remain consistent with the approach throughout this dissertation of utilizing data one year in advance of the data for the dependent variable, level of benefits, since the decisions leading to the level of benefits for a particular year would have been made in the previous year. Tables with this data can be found in Appendix F (Tables F.1-F.4); the data provided in Chapter IV was from more current years.

The Government Performance Project (The Pew Center on the States, 2005) was referenced to ascertain a measure of human resources management performance across the states. The project grades the states in overall performance and various components of management. One of those components is "People". This assessment considers how well each of the states mange their employees. The evaluation considers strategic workforce planning, hiring and retaining employees, training and development, and managing employee performance. The "People" scores on the Government Performance Project for 2005 were selected as a control variable. States were graded on a letter scale (A-D) which was converted to a numerical equivalent scale (4-1); the scores for each state can be viewed in Appendix F (Tables F.5 and F.6).

The average age of the state workforce was found for forty-one of the states in 2002 (Carroll and Moss). As stated earlier, an attempt has been made to utilize data for the independent and control variables from the year previous to the independent variable. Age data for 2005, however, could not be found; the 2002 data likely represents the

relative variation between the states even if the actual average age might have changed in subsequent years. Regrettably, having data for only forty-one states, necessitated eliminating Connecticut, Florida, Hawaii, Maine, Maryland, Massachusetts, Nebraska, Tennessee, and West Virginia from this particular analysis (see Appendix Table F.7).

TABLE 5.9 below is a table of descriptive statistics associated with the control variables:

TABLE 5.9 DESCRIPTIVE STATISTICS FOR CONTROL VARIABLES

Variable	*Minimum*	*Maximum*	*Mean*	*Standard Deviation*	*N*
Average State Obesity and Smoking Rates Ranking*	3	47	25.2200	13.50932	50
Average of the Healthiest States Rankings *	1.5	49.5	25.48	14.33704	50
Government Performance Project – People Score	1.33	4.0	2.64	.55057	50
Average Age of State Government Employees	41.5	48	44.2561	1.58458	41

The dependent variable is the level of benefits

Note - *The average of the Healthiest States Rankings is reverse coded with lower numbers representing healthier states.

West Virginia had the worst average of smoking and obesity rates and Hawaii had the best. In terms of the healthiest state ranking, Louisiana and Mississippi were tied as the worst and New Hampshire and Vermont as the best. Georgia garnered the best Government Performance “People” score and Wyoming and Rhode Island tied for the lowest score. Of the states with available data, the state government with the average

youngest workers was Delaware and the average oldest workers were in Ohio and Rhode Island.

Correlation

Having identified a set of control variables, bivariate correlation analysis was performed to ascertain their potential association with the dependent variable, level of benefits. Neither the Government Performance Project "People" score nor the average age of state government employees were found to have a statistically significant association with the level of benefits. It is feasible that had the average age for all fifty states, rather than just forty-one, been available a stronger relationship might have been identified.

Surprisingly, the obesity and smoking rating also was not found to be statistically significant. The healthiest state ranking was, however, statistically significant. TABLE 5.10 below is a table of findings:

TABLE 5.10 MEASURE OF ASSOCIATION OF CONTROL VARIABLES TO THE DEPENDENT VARIABLE, LEVEL OF BENEFITS

Control Variable	*Pearson's correlation*	*Significance (1-tailed)*	*N*
Average State Obesity and Smoking Rates Ranking	.214	.068	50
Average of the Healthiest States Rankings	-.393	.002	50
Government Performance Project – People Score	.037	.400	50
Average Age of State Government Employees	.092	.283	41

The negative correlation associated with the average of the healthiest states variable is due to reverse coding; the healthiest state in both the United Health Foundation and the Morgan Quitno Press rankings was ranked as number one and the least healthy state as number 50. As can be seen in the above table, the correlation between the healthiest states ranking and the level of benefits is one that is generally considered quite strong in the social sciences. Clearly, healthier states are providing a higher level of benefits to their employees.

Multiple regression

Finally, multiple regression analysis will enable us to determine if, and how much, the combination of the originally established dependent variables and the control variables are likely to predict the value of the dependent variable.

Given that the Government Performance Project "People" score, the average age of state government employees, and the obesity and smoking rankings were not found to have a statistically significant association with the dependent variable they were not included in the model chosen for this regression. Model 1C analyzed the combined affect of the hypothesized independent variables and the healthiest state rankings in predicting the value of the dependent variable. The model was not found to be statistically significant; the results are shown in TABLE 5.11 below.

TABLE 5.11 RESULTS OF MULTIPLE REGRESSION ANALYSIS FOR MODEL 1C

Model	*R^2*	*Adjusted R^2*	*F score*	*Significance*
1 C *(includes hypothesized variables and healthy state ranking)*	.192	.100	2.087	.085

Variation of the dependent variable

In Chapter III it was argued that in operationalizing the "level of benefits" an adjustment should be made for differences in health care costs across the states. By so doing, it was contended that the measurement would better reflect the "relative" generosity of one state versus another. What would happen, however, if we were to want to analyze the "absolute" generosity of one state versus another rather than the "relative" generosity? Yes, there are real differences in health care costs, but there are also

differences between the states in their economic conditions and ability to finance their operations. Not to counter the original argument, but to provide an additional perspective, an analysis was conducted wherein the level of benefits was defined solely as the state government contribution to the family premium; no adjustments were made for differences between a state's and the national per capita health care expenditure. Bivariate correlation analysis measuring the association of the newly defined dependent variable (state contribution to family premium) with the originally hypothesized independent variables (median family income, percent union membership, government ideology, and a moralistic political culture), as well as multiple regression to assess the combined effect of the variables, was performed. The results are found in TABLE 5.12 and 5.13 below:

TABLE 5.12 MEASURE OF ASSOCIATION BETWEEN STATE CONTRIBUTION, AS THE DEPENDENT VARIABLE, AND THE INDEPENDENT VARIABLES

Independent Variable	*Pearson's correlation*	*Significance (1-tailed)*	*N*
Median family income	.408	.002	50
Union membership	.491	.000	50
Government ideology	.180	.105	50
Moralistic political culture	.208	.074	50

The dependent variable is the state government contribution to the family health care insurance premium.

As compared to the correlation results with the original dependent variable, the Pearson's correlation for both median family income and union membership have increased and both variables remain statistically significant. Government ideology continues to fail to achieve a level of statistical significance and a moralistic political culture no longer is seen as statistically significant. The following table shows the results of the multiple regression analysis.

TABLE 5.13 MULTIPLE REGRESSION ANALYSIS UTILIZING STATE CONTRIBUTION AS THE DEPENDENT VARIABLE

Variable	*Regression Coefficient*	*Standard error*	*Standardized coefficient*	*t-statistic*	*Significance level (one-sided)*
Constant	244.706	281.039		.871	.194
Median family income	.007	.006	.178	1.119	.134
Union membership	5.772	2.752	.360	2.097	.021
Government ideology	.225	1.493	.021	.151	.440
Moralistic political culture	82.976	76.792	.138	1.081	.143
R^2	.282				
Adjusted R^2	.218				
F	4.412 (p-value = .004)				

This model is stronger than the one originally stipulated. Substituting the state contribution for the computed level of benefits results in a model that demonstrates 28.2% (the unadjusted R^2), rather than 18.7%, of the variation in the dependent variable is explained by the independent variables specified in the model. Further, the percent of union membership rises to the level of statistical significance, whereas, in the original model, none of the independent variables were statistically significant.

When utilizing the state contribution to the family monthly health care insurance premium as the dependent variable, the model indicates that for each percentage increase in a state's union membership, there is a corresponding increase of $5.77 in a state's contribution to the monthly premium while controlling for all other variables in the model. If the regression coefficients that are not statistically significant are interpreted as the population coefficients, then, any increase in a state's median family income corresponds to an expected $7 increase in the level of benefits for a $1,000 increase in median family income controlling for all other variables in the model. Further, for each unit increase in the liberal ranking of a state there is a corresponding increase of $.22 in the state's level of benefits, and states with a moralistic political culture have a level of benefit averaging $82.97 a month higher than non-moralistic states while controlling for all other variables in the model.

Adding the control variables (either healthiest state ranking and the Government Performance Project [GPP] People rating or the obesity and smoking ranking and GPP People rating) to this model had minimal impact and the one statistically significant independent variable, union membership, failed to maintain significance in either of the revised models.

An alternative variation of the dependent variable would be to substitute the actual percentage of the family premium paid by the state for the computed level of benefit. This model was, however, minimally weaker than the model utilizing the actual state contribution.

The following Discussion chapter will elaborate upon the implications of the findings.

CHAPTER VI

DISCUSSION

The literature provides sufficient information to assume an association between the level of health care benefits provided to state government employees and a state's economic condition, level of union membership, degree of liberalism attributed to the state, and the likelihood that a state is considered to have a moralistic political culture. The goal of this dissertation has been to evaluate those assumptions and to consider the impact of these potentially contributing factors. As the research advanced, additional control variables were considered as well as an alternative dependent variable. The impact of those variables will be discussed in the latter part of this chapter; first will be a discussion of the research as originally envisioned.

Hypotheses

H_1 stated, "There is a positive association between the level of benefits and the level of a state's economic condition". As expected, this was found to be statistically significant and, additionally, had the strongest relationship with the level of benefits of the four independent variables assessed by bivariate correlation. The top quartile of states with the highest median family income had a computed level of benefit of approximately $884 as compared to the approximate $646 level of benefit for the bottom

quartile states. Further, the top twenty-five percent of these states funded 83.2% of a family's total monthly health care premium as compared to 73.7% of the total for the bottom quadrant of states. Clearly a state's economic condition, as measured by the median family income, positively impacts the level of benefits afforded to the state's government employees. Difficult economic times combined with rising health care costs will provide challenges for the designers of state health care workers' benefit plans.

H_2 stated, " There is a positive association between the level of benefits and the level of union membership of a state's government employees" Like the first hypotheses, H_2 was also found to be statistically significant and resulted in the second strongest relationship with the level of benefits of the four independent variables. This is particularly interesting given Reddick and Coggburn's (2007) finding, cited earlier that state human resource directors rank union and/or collective bargaining to be the lowest amongst seven possible factors affecting choice of a health care plan. Various considerations could contribute to this difference. Potentially, union impact on benefit levels has become so imbedded that it is simply considered part of the normative situation and not as likely to be cited by human resource personnel. It is also possible that the difference is a reflection of measurement variances. The unit of measure in this analysis was the percent of all public employees within a state. It is feasible that the inclusion of non-state government employees (i.e. city and county employees) could have skewed results in this analysis.

The top quartile of states with the highest percentage of union membership had a computed level of benefit of approximately $968 as compared to the approximate $718 level of benefit for the bottom quartile states. Further, the top twenty-five percent of

these states funded 89.1% of a family's total monthly health care premium as compared to 71.9% of the total for the bottom quadrant of states. The percent of union membership of public employees within a state has an obvious and substantive impact on the level of benefits afforded to the states' government employees.

H_3 stated, "There is a positive association between the level of benefits and the degree of liberalism attributed to the state." This association did not prove to be statistically significant. In measuring this variable it was decided that the ideology of the state government, versus that of its general citizenry, would be utilized since the level of benefits was an issue determined by political elites and, though of interest to public employees, do not usually rise to the level of attention of the broader public.

However, Erikson, Wright, & McIver (1989) did find that the ideology of a state legislature was tempered by state public opinion and so it seemed prudent to investigate the possibility of the citizens' ideology having an impact. The original decision was, in fact, valid in that a measure of citizens' ideology likewise did not prove to be statistically significant (p-value of .415). The measure, developed by Berry et al (1998), utilizes election results by congressional district within each state. An ideology score, based upon ADA and COPE ratings, is assigned to each congressional incumbent and an estimated score is developed for each challenger. The estimated score is derived from the average ideology score of all incumbents in the state from the challenger's party. By including an ideology score for the loser as well as the winner, the resulting score incorporates a more inclusive picture of the broader voting population's ideological bent. To further assess any possible citizen ideology impact, a bivariate correlation between the level of benefits and the results of the 2004 presidential election was conducted.

Utilizing the percentage of votes for John Kerry in each of the states as the ideology measure no statistically significant association was found with the level of benefits (p-value of .101).

We can, therefore, conclude that the level of benefits does not appear to be sensitive to the degree of liberalism present within a state, whether the ideology is measured as that of the political elite (i.e. government ideology) or that of the broader population (i.e. citizen ideology). This finding, in combination with the finding for H_1, resonates with the related conclusions cited earlier of Buchanan, Cappelleri and Ohsfeklt (1991) that economic conditions rather than political ideology had a significant impact on state Medicaid spending levels. Both findings impact the availability of health care benefits for citizens, albeit in different circumstances. Though Medicaid is a redistributive policy, support of benefits for government employees is a distributive policy. Is it likely that distributive policies are even less sensitive to ideological differences?

H_4 stated that, "Variations in the level of benefits are explained by a state's political culture; moralistic states are more likely than traditionalistic or individualistic states to be associated with a higher level of benefits." This variable, like median family income and union membership, was found to be statistically significant. Moralistic states had a computed level of benefit of approximately $906 as compared to the approximate $759 level of benefit for all other states ($814 for individualistic, $701 for traditionalistic). Further, the moralistic states funded 84.1% of a family's total monthly health care premium as compared to 77.6% of the total for the remaining states (83.3% for individualistic and 71.5% for traditionalistic).

Political culture might be thought of as a predisposition towards action or non-action with moralistic states predisposed to act for improvement of social and economic conditions. Support for government employee health care benefits would, as shown, be more likely in such a climate than in a traditionalistic state that is predisposed to maintain the status quo in support of the existing social order or in an individualistic state predisposed towards actions favoring private initiatives. As changes occur in the structure of health care benefit offerings it will be interesting to see if individualistic states are more inclined to support health savings accounts. Approaches taken by moralistic states will also likely be of interest; Elazar (1984, p.167), utilizing data developed by Walker, saw moralistic states as leaders in program innovation.

Multiple regression models

Regression is a valuable tool that can provide an increased explanatory value to the analysis of the impact of multiple independent variables. The primary model chosen for analysis incorporated all fifty states and all four independent variables. The results of that analysis indicated a statistically significant model; however, none of the four variables was found to be significant.

The p-value for any one variable is based upon the unique contribution of that variable above the contribution of the other variables. Given that union membership was found to be correlated with median family income, as well as with government ideology, these variables carry some of the same information and their strength is, therefore, reduced when viewed in the context of the multiple regression model. In fact, when median family income is removed from the model, union membership rose to the level of

statistical significance and, likewise, when union membership was removed from the model, median family income rose to the level of statistical significance.

Considering the presence of all the variables in the real world environment, the size of the median family income will likely exert the greatest upward pressure on the level of benefit. However, the independent significance of both the proportion of union members within the ranks of public employees and a moralistic political culture will impact the level of benefit as well.

Change is coming to the health care insurance marketplace be it though price or through structural modifications. That change will impact decisions made by state governments relative to the benefits provided to their employees and their families. The economic condition of the state will influence and, in some instances, dictate the direction taken by the individual states. Government workers in states with a large percentage of union members may well benefit from the pressure exerted by the unions to address the health care needs of their members. Response to the dynamics of the health insurance marketplace will be tempered by the political culture of the states. The predisposition of the moralistic states to promote the public good is likely to translate to enhanced benefits for those government employees as compared to those in other states.

Having completed the research originally specified by this dissertation, the next question is "What else?" What else contributes to the level of benefits? Though a statistically significant model, it was moderately weak. As shown in the results chapter, the addition of the healthiest state ranking, as a control variable, resulted in a model that was not statistically significant. However, the healthiest state ranking had the highest Pearson Correlation, -.393, with the dependent variable of any of the tested variables.

The quartile of states with the healthiest state rankings had a computed level of benefit of approximately $967 as compared to the approximate $699 level of benefit for the least healthy quartile of states. Further, the top twenty-five percent of these states funded 85.6% of a family's total health care premium as compared to 71.7% of the total for the bottom quadrant of states. The health ranking of a state has an obvious and substantive association with the level of benefits afforded to the states' government employees. But what drives the association? Do healthier states simply spend more on health care benefits or do the greater benefits create a healthier state? One could logically look at this from both directions. In a healthier state perhaps there is a greater value placed on health care that increases the likelihood of providing greater benefits; likewise, providing increased benefits may result in increased, and perhaps improved, health care leading to improved health outcomes and an increase in the state's ranking.

Much has been learned from the models studied, but what else might affect the level of benefits? Are there a multitude of factors, each smaller in its impact than those already identified, or are there one or more dominant factors to be considered? Identification and assessment of additional possibly contributing factors is a worthy pursuit.

In a white paper prepared for the National Association of State Personnel Executives (2006), a number of potentially contributing factors influencing the cost of health care benefits between state governments and large private employers were discussed. These factors may well play a role in the differing level of benefits between the states as well. Some factors considered were age of the workforce, geographic location of the workforce, potential for incongruent risk pools, and multiplicity of offered

plans. The “level of benefit” may not be a reflection of broader coverage, but of higher premium costs brought on by one or more of these factors. Does State A have an older workforce than State B? Does State C have more employees located in rural areas with an associated increased cost structure for health care than the employees of State D? Has State E placed non-state employees under the umbrella of their employee health plan and adversely affected the size of their risk as compared to State F? Does State G offer a broader array of health plan options to their employees than that offered by State H and does that increased offering reduce their purchasing power with a single vendor and increase their administrative costs?

Additional research opportunities exist to further ascertain the factors contributing to the variation in the level of health care benefits to state government employees across the country. Future research may refine and redefine “level of benefits”. As was shown in this research, a different perspective on measuring benefits affected the outcome and strengthened the model. What is important in viewing the results of this dissertation research is to accept them as a starting point. As was pointed out in both the Introduction and the Review of the Literature, a scant amount of research exists on this topic. A base line of information has been developed that will, hopefully stimulate additional approaches and research efforts.

CHAPTER VII

CONCLUSION

In Mississippi, the family of a state government employee pays an in network deductible of $1,000 prior to the first dollar of health care insurance coverage. For some families the amount of the deductible can be a substantial barrier to accessing care. Understanding the variations between states and the factors that lead to those variations can ultimately lead to a healthier society if we appropriately make use of findings. Knowing that there is a relationship between the overall health of the state and the level of benefits afforded its government workers allows advocates of increased benefits to place their requests in a broader context. Having found that states with a moralistic political culture are more likely than individualistic or traditionalistic states to provide a higher level of health care benefits for their employees will not enable a state to change its' political culture. However, having recognized one aspect that affects the availability of benefits, recommendations may be developed and advocated for in a manner more resonant with the prevailing culture. Likewise, adaptations may be made in greater recognition of a state's economic condition or union membership if needed.

The health of a state's employees likely impacts their productivity; the availability of benefits, as found by Light (1999) and others, impacts motivation. The quality of health care insurance is an issue for state governments not only in terms of their citizenry,

but also in terms of their employee base. Understanding differences between states and the factors that drive those differences has the potential of improving lives and the functioning of state governments.

The practical considerations made this an important research endeavor, but what of its contribution to theory? At the end of the day, how is the body of knowledge in the field of public policy and administration advanced by this inquiry? The dissertation is Stage 1, it has uncovered some of the differences and the factors influencing those differences, it has done that in recognition that those differences have a potential impact on the ability of state government to attract and maintain employees of merit. Stage 1 has not directly assessed the effect of that potential impact, but it can provide the way for further study. It suggests that future endeavors consider the following:

- If the theory of inequity allows for assessment by an internal standard that is influenced by perceived market values, might a sense of inequity arise when an employee in State A believes his or her coverage is significantly less than that available to employees in State B?

- If the theory of inequity allows for assessment by an internal standard that is influenced by historical knowledge, might a sense of inequity arise as benefits are restructured within his or her own state?

- In attempting to either achieve equity, or reduce inequity, might an individual adopt strategies of giving "voice" to their dissatisfaction in hopes of reducing the inequity, "neglect" parts of their job, or "exit" to reduce the inequity?

Stage 1 was, however, significant in and of itself. In a country that spends $2.1 trillion a year, 16% of its gross domestic product, on health care and debates whether we should continue with a host of different plans, provide coverage for some and not for others, or move to a national plan that might be a single plan or allow for optional public and private plans while incorporating the principal of universal coverage, this research allows us to look at how and why states vary in their treatment and delivery of coverage to more than five million employees and their dependents.

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APPENDIX A

LEVEL OF BENEFIT

TABLE A.1 LEVEL OF BENEFIT BY STATE, 2006 ALPHABETICAL

State	*Level of Benefit*	*State*	*Level of Benefit*
Alabama	$668.73	Montana	$526.22
Alaska	$624.95	Nebraska	$1,077.21
Arizona	$1,053.92	Nevada	$782.30
Arkansas	$568.00	New Hampshire	$1,834.47
California	$919.23	New Jersey	$760.35
Colorado	$515.49	New Mexico	$650.92
Connecticut	$828.91	New York	$671.19
Delaware	$882.61	North Carolina	$326.83
Florida	$689.81	North Dakota	$503.87
Georgia	$674.41	Ohio	$787.36
Hawaii	$521.11	Oklahoma	$1,179.92
Idaho	$685.55	Oregon	$1,085.80
Illinois	$1,094.45	Pennsylvania	$530.55
Indiana	$915.50	Rhode Island	$936.67
Iowa	$971.91	South Carolina	$546.48
Kansas	$593.18	South Dakota	$411.93
Kentucky	$678.95	Tennessee	$856.26
Louisiana	$677.04	Texas	$770.55
Maine	$902.67	Utah	$1,174.04
Maryland	$656.35	Vermont	$1,045.07
Massachusetts	$917.11	Virginia	$973.99
Michigan	$1,240.08	Washington	$988.75
Minnesota	$890.53	West Virginia	$575.86
Mississippi	$318.50	Wisconsin	$1,118.51
Missouri	$948.11	Wyoming	$900.18

TABLE A.2 LEVEL OF BENEFIT BY STATE, 2006 RANK ORDERED

State	*Level of Benefit*	*State*	*Level of Benefit*
New Hampshire	$1,834.47	Nevada	$782.30
Michigan	$1,240.08	Texas	$770.55
Oklahoma	$1,179.92	New Jersey	$760.35
Utah	$1,174.04	Florida	$689.81
Wisconsin	$1,118.51	Idaho	$685.55
Illinois	$1,094.45	Kentucky	$678.95
Oregon	$1,085.80	Louisiana	$677.04
Nebraska	$1,077.21	Georgia	$674.41
Arizona	$1,053.92	New York	$671.19
Vermont	$1,045.07	Alabama	$668.73
Washington	$988.75	Maryland	$656.35
Virginia	$973.99	New Mexico	$650.92
Iowa	$971.91	Alaska	$624.95
Missouri	$948.11	Kansas	$593.18
Rhode Island	$936.67	West Virginia	$575.86
California	$919.23	Arkansas	$568.00
Massachusetts	$917.11	South Carolina	$546.48
Indiana	$915.50	Pennsylvania	$530.55
Maine	$902.67	Montana	$526.22
Wyoming	$900.18	Hawaii	$521.11
Minnesota	$890.53	Colorado	$515.49
Delaware	$882.61	North Dakota	$503.87
Tennessee	$856.26	South Dakota	$411.93
Connecticut	$828.91	North Carolina	$326.83
Ohio	$787.36	Mississippi	$318.50

TABLE A.3 ELEMENTS COMPUTED IN DERIVING THE LEVEL OF BENEFITS

State	State Government's Contribution to Family Premium 2006	State per capita Health Care Expenditure 2005	National per capita Health Care Expenditure 2005	Divisor *State per capita ÷ National per capita health care expenditure*	Computed Level of Benefit
Alabama	$650	$5,135	$5,283	0.972	$668.73
Alaska	$763	$6,450	$5,283	1.221	$624.95
Arizona	$819	$4,103	$5,283	0.777	$1,053.92
Arkansas	$523	$4,863	$5,283	0.920	$568.00
California	$807	$4,638	$5,283	0.878	$919.23
Colorado	$460	$4,717	$5,283	0.893	$515.49
Connecticut	$995	$6,344	$5,283	1.201	$828.91
Delaware	$1054	$6,306	$5,283	1.194	$882.61
Florida	$716	$5,483	$5,283	1.038	$689.81
Georgia	$587	$4,600	$5,283	0.871	$674.41
Hawaii	$487	$4,941	$5,283	0.935	$521.11
Idaho	$577	$4,444	$5,283	0.841	$685.55
Illinois	$1097	$5,293	$5,283	1.002	$1,094.45
Indiana	$918	$5,295	$5,283	1.002	$915.50
Iowa	$990	$5,380	$5,283	1.018	$971.91
Kansas	$604	$5,382	$5,283	1.019	$593.18
Kentucky	$703	$5,473	$5,283	1.036	$678.95
Louisiana	$646	$5,040	$5,283	0.954	$677.04
Maine	$1117	$6,540	$5,283	1.238	$902.67
Maryland	$694	$5,590	$5,283	1.058	$656.35
Massachusetts	$1160	$6,683	$5,283	1.265	$917.11
Michigan	$1187	$5,058	$5,283	0.957	$1,240.08
Minnesota	$977	$5,795	$5,283	1.097	$890.53
Mississippi	$305	$5,059	$5,283	0.958	$318.50
Missouri	$977	$5,444	$5,283	1.030	$948.11
Montana	$506	$5,080	$5,283	0.962	$526.22

TABLE A.3 Continued

State	State Government's Contribution to Family Premium 2006	State per capita Health Care Expenditure 2005	National per capita Health Care Expenditure 2005	Divisor *State per capita ÷ National per capita health care expenditure*	Computed Level of Benefit
Nebraska	$1142	$5,599	$5,283	1.060	$1,077.21
Nevada	$677	$4,569	$5,283	0.865	$782.30
New Hampshire	$1886	$5,432	$5,283	1.028	$1,834.47
New Jersey	$836	$5,807	$5,283	1.099	$760.35
New Mexico	$551	$4,471	$5,283	0.846	$650.92
New York	$830	$6,535	$5,283	1.237	$671.19
North Carolina	$321	$5,191	$5,283	0.983	$326.83
North Dakota	$554	$5,808	$5,283	1.099	$503.87
Ohio	$853	$5,725	$5,283	1.084	$787.36
Oklahoma	$1098	$4,917	$5,283	0.931	$1,179.92
Oregon	$1003	$4,880	$5,283	0.924	$1,085.80
Pennsylvania	$596	$5,933	$5,283	1.123	$530.55
Rhode Island	$1098	$6,193	$5,283	1.172	$936.67
South Carolina	$529	$5,114	$5,283	0.968	$546.48
South Dakota	$415	$5,327	$5,283	1.008	$411.93
Tennessee	$886	$5,464	$5,283	1.034	$856.26
Texas	$671	$4,601	$5,283	0.871	$770.55
Utah	$883	$3,972	$5,283	0.752	$1,174.04
Vermont	$1201	$6,069	$5,283	1.149	$1,045.07
Virginia	$889	$4,822	$5,283	0.913	$973.99
Washington	$953	$5,092	$5,283	0.964	$988.75
West Virginia	$649	$5,954	$5,283	1.127	$575.86
Wisconsin	$1200	$5,670	$5,283	1.073	$1,118.51
Wyoming	$897	$5,265	$5,283	0.997	$900.18

APPENDIX B

MEDIAN FAMILY INCOME

TABLE B.1 MEDIAN FAMILY INCOME BY STATE, 2004-05 ALPHABETICAL

State	*Median Family Income*	*State*	*Median Family Income*
Alabama	$38,733	Montana	$37,391
Alaska	$58,249	Nebraska	$48,116
Arizona	$46,765	Nevada	$50,088
Arkansas	$37,601	New Hampshire	$59,749
California	$52,996	New Jersey	$62,223
Colorado	$53,210	New Mexico	$41,226
Connecticut	$58,756	New York	$48,191
Delaware	$52,101	North Carolina	$43,193
Florida	$43,834	North Dakota	$42,720
Georgia	$45,589	Ohio	$45,805
Hawaii	$60,787	Oklahoma	$40,582
Idaho	$46,486	Oregon	$44,682
Illinois	$49,584	Pennsylvania	$47,449
Indiana	$44,505	Rhode Island	$51,136
Iowa	$47,170	South Carolina	$41,424
Kansas	$43,620	South Dakota	$44,222
Kentucky	$37,956	Tennessee	$40,668
Louisiana	$38,671	Texas	$43,484
Maine	$44,739	Utah	$55,455
Maryland	$61,724	Vermont	$51,443
Massachusetts	$56,690	Virginia	$54,102
Michigan	$46,272	Washington	$52,797
Minnesota	$57,939	West Virginia	$36,631
Mississippi	$35,525	Wisconsin	$47,464
Missouri	$44,686	Wyoming	$47,321

Source: U. S. Census Bureau (n.d.). Two-year average median household income by state: 2004-2006

TABLE B.2 MEDIAN FAMILY INCOME BY STATE, 2004-05 RANK ORDERED

State	*Median Family Income*	*State*	*Median Family Income*
New Jersey	$62,223	Idaho	$46,486
Maryland	$61,724	Michigan	$46,272
Hawaii	$60,787	Ohio	$45,805
New Hampshire	$59,749	Georgia	$45,589
Connecticut	$58,756	Maine	$44,739
Alaska	$58,249	Missouri	$44,686
Minnesota	$57,939	Oregon	$44,682
Massachusetts	$56,690	Indiana	$44,505
Utah	$55,455	South Dakota	$44,222
Virginia	$54,102	Florida	$43,834
Colorado	$53,210	Kansas	$43,620
California	$52,996	Texas	$43,484
Washington	$52,797	North Carolina	$43,193
Delaware	$52,101	North Dakota	$42,720
Vermont	$51,443	South Carolina	$41,424
Rhode Island	$51,136	New Mexico	$41,226
Nevada	$50,088	Tennessee	$40,668
Illinois	$49,584	Oklahoma	$40,582
New York	$48,191	Alabama	$38,733
Nebraska	$48,116	Louisiana	$38,671
Wisconsin	$47,464	Kentucky	$37,956
Pennsylvania	$47,449	Arkansas	$37,601
Wyoming	$47,321	Montana	$37,391
Iowa	$47,170	West Virginia	$36,631
Arizona	$46,765	Mississippi	$35,525

Source: U. S. Census Bureau (n.d.). Two-year average median household income by state: 2004-2006

APPENDIX C

PERCENT UNION MEMBERSHIP

TABLE C.1 PERCENT UNION MEMBERSHIP OF PUBLIC EMPLOYEES BY STATE, 2005 ALPHABETICAL

State	*Union Membership*	*State*	*Union Membership*
Alabama	30.9	Montana	28.6
Alaska	48.5	Nebraska	26.9
Arizona	18.1	Nevada	28.2
Arkansas	12.9	New Hampshire	49.9
California	53.8	New Jersey	64.1
Colorado	23.8	New Mexico	21.6
Connecticut	63.5	New York	68.9
Delaware	38.4	North Carolina	8.7
Florida	22.3	North Dakota	20.7
Georgia	12.1	Ohio	46.0
Hawaii	57.7	Oklahoma	15.5
Idaho	14.2	Oregon	48.9
Illinois	48.5	Pennsylvania	48.5
Indiana	28.2	Rhode Island	63.6
Iowa	32.8	South Carolina	7.4
Kansas	14.8	South Dakota	19.9
Kentucky	18.6	Tennessee	17.1
Louisiana	14.0	Texas	16.8
Maine	42.8	Utah	15.7
Maryland	32.3	Vermont	38.5
Massachusetts	58.3	Virginia	10.4
Michigan	58.0	Washington	51.4
Minnesota	52.6	West Virginia	28.3
Mississippi	14.6	Wisconsin	49.5
Missouri	21.4	Wyoming	15.3

Source: Hirsch, B. & Macpherson, D. (2008). Unionstats.com

TABLE C.2 PERCENT UNION MEMBERSHIP OF PUBLIC EMPLOYEES BY STATE, 2005 RANK ORDERED

State	*Union Membership*	*State*	*Union Membership*
New York	68.9	Indiana	28.2
New Jersey	64.1	Nevada	28.2
Rhode Island	63.6	Nebraska	26.9
Connecticut	63.5	Colorado	23.8
Massachusetts	58.3	Florida	22.3
Michigan	58.0	New Mexico	21.6
Hawaii	57.7	Missouri	21.4
California	53.8	North Dakota	20.7
Minnesota	52.6	South Dakota	19.9
Washington	51.4	Kentucky	18.6
New Hampshire	49.9	Arizona	18.1
Wisconsin	49.5	Tennessee	17.1
Oregon	48.9	Texas	16.8
Alaska	48.5	Utah	15.7
Illinois	48.5	Oklahoma	15.5
Pennsylvania	48.5	Wyoming	15.3
Ohio	46.0	Kansas	14.8
Maine	42.8	Mississippi	14.6
Vermont	38.5	Idaho	14.2
Delaware	38.4	Louisiana	14.0
Iowa	32.8	Arkansas	12.9
Maryland	32.3	Georgia	12.1
Alabama	30.9	Virginia	10.4
Montana	28.6	North Carolina	8.7
West Virginia	28.3	South Carolina	7.4

Source: Hirsch, B. & Macpherson, D. (2008). Unionstats.com

APPENDIX D

GOVERNMENT IDEOLOGY SCORE

TABLE D.1 GOVERNMENT IDEOLOGY SCORE BY STATE, 2005
ALPHABETICAL

State	*Government Ideology*	*State*	*Government Ideology*
Alabama	42.625	Montana	73.14538
Alaska	13.16667	Nebraska	16.875
Arizona	52.875	Nevada	37.12738
Arkansas	43.75	New Hampshire	46.2595
California	49.59286	New Jersey	88.51563
Colorado	37.31163	New Mexico	91.99048
Connecticut	69.58334	New York	41.10945
Delaware	72.5625	North Carolina	84.37583
Florida	10.3421	North Dakota	20.14565
Georgia	14.18442	Ohio	16.57121
Hawaii	68.84393	Oklahoma	44.36544
Idaho	20	Oregon	79.35
Illinois	85.06613	Pennsylvania	60.11131
Indiana	18.335	Rhode Island	77.83333
Iowa	68.91275	South Carolina	14.15885
Kansas	45	South Dakota	15.5
Kentucky	27.02015	Tennessee	60.56313
Louisiana	88.66666	Texas	10.8615
Maine	88.59511	Utah	10.125
Maryland	55.53125	Vermont	89.4243
Massachusetts	68.40019	Virginia	53.00834
Michigan	62.27471	Washington	82.48286
Minnesota	38.77166	West Virginia	89.75
Mississippi	40.37788	Wisconsin	54.11048
Missouri	11.31175	Wyoming	45.92506

Source: Fording, R. (n.d.) *State citizen and government ideology* (Data file).

TABLE D.2 GOVERNMENT IDEOLOGY SCORE BY STATE, 2005 RANK ORDERED

State	*Government Ideology*	*State*	*Government Ideology*
New Mexico	91.99048	New Hampshire	46.2595
West Virginia	89.75	Wyoming	45.92506
Vermont	89.4243	Kansas	45
Louisiana	88.66666	Oklahoma	44.36544
Maine	88.59511	Arkansas	43.75
New Jersey	88.51563	Alabama	42.625
Illinois	85.06613	New York	41.10945
North Carolina	84.37583	Mississippi	40.37788
Washington	82.48286	Minnesota	38.77166
Oregon	79.35	Colorado	37.31163
Rhode Island	77.83333	Nevada	37.12738
Montana	73.14538	Kentucky	27.02015
Delaware	72.5625	North Dakota	20.14565
Connecticut	69.58334	Idaho	20
Iowa	68.91275	Indiana	18.335
Hawaii	68.84393	Nebraska	16.875
Massachusetts	68.40019	Ohio	16.57121
Michigan	62.27471	South Dakota	15.5
Tennessee	60.56313	Georgia	14.18442
Pennsylvania	60.11131	South Carolina	14.15885
Maryland	55.53125	Alaska	13.16667
Wisconsin	54.11048	Missouri	11.31175
Virginia	53.00834	Texas	10.8615
Arizona	52.875	Florida	10.3421
California	49.59286	Utah	10.125

Source: Fording, R. (n.d.) *State citizen and government ideology* (Data file).

APPENDIX E

ELAZAR'S POLITICAL CULTURE CLASSIFICATION

TABLE E.1 ELAZAR'S POLITICAL CULTURE CLASSIFICATION BY STATE

Moralistic	***Individualistic***	***Traditionalistic***
California	Alaska	Alabama
Colorado	Connecticut	Arizona
Idaho	Delaware	Arkansas
Iowa	Hawaii	Florida
Kansas	Illinois	Georgia
Maine	Indiana	Kentucky
Michigan	Maryland	Louisiana
Minnesota	Massachusetts	Mississippi
Montana	Missouri	New Mexico
New Hampshire	Nebraska	North Carolina
North Dakota	Nevada	Oklahoma
Oregon	New Jersey	South Carolina
South Dakota	New York	Tennessee
Utah	Ohio	Texas
Vermont	Pennsylvania	Virginia
Washington	Rhode Island	West Virginia
Wisconsin	Wyoming	

Source: Elazar, D. (1984)

APPENDIX F

CONTROL VARIABLES

TABLE F.1 OBESITY/SMOKING RANKINGS, ALPHABETICAL BY STATE, 2005

State	***Trust for America Obesity Rankings 2005***	***CDC/BRFSS Adults Who Are Current Smokers 2005***	***CDC/BRFSS Adults Who Are Current Smokers Ranking 2005***	***Average of the two rankings***
Alabama	2	24.8	7	4.5
Alaska	19	24.9	6	12.5
Arizona	39	20.2	30	34.5
Arkansas	11	23.5	10	10.5
California	31	15.2	49	40
Colorado	49	19.8	35	42
Connecticut	45	16.5	48	46.5
Delaware	27	20.6	25	26
Florida	37	21.7	19	28
Georgia	12	22.1	17	14.5
Hawaii	N/A	17	47	47
Idaho	36	17.9	44	40
Illinois	22	19.9	34	28
Indiana	9	27.3	2	5.5
Iowa	20	20.4	28	24
Kansas	22	17.8	45	33.5
Kentucky	6	28.7	1	3.5
Louisiana	4	22.6	13	8.5
Maine	32	20.8	23	27.5
Maryland	29	18.9	40	34.5
Massachusetts	48	18.1	42	45
Michigan	6	22	18	12
Minnesota	25	20	32	28.5
Mississippi	1	23.6	8	4.5
Missouri	16	23.4	11	13.5
Montana	44	19.2	39	41.5

TABLE F.1 Continued

State	*Trust for America Obesity Rankings 2005*	*CDC/BRFSS Adults Who Are Current Smokers 2005*	*CDC/BRFSS Adults Who Are Current Smokers Ranking 2005*	*Average of the two rankings*
Nebraska	20	21.3	21	20.5
Nevada	32	23.1	12	22
New Hampshire	42	20.4	28	35
New Jersey	39	18	43	41
New Mexico	38	21.5	20	29
New York	34	20.5	27	30.5
North Carolina	16	22.6	13	14.5
North Dakota	16	20.1	31	23.5
Ohio	13	22.3	16	14.5
Oklahoma	14	25.1	5	9.5
Oregon	35	18.5	41	38
Pennsylvania	15	23.6	8	11.5
Rhode Island	47	19.8	35	41
South Carolina	10	22.5	15	12.5
South Dakota	26	19.8	35	30.5
Tennessee	5	26.7	3	4
Texas	6	20	32	19
Utah	43	11.5	50	46.5
Vermont	44	19.3	38	41
Virginia	22	20.6	25	23.5
Washington	29	17.6	46	37.5
West Virginia	3	26.7	3	3
Wisconsin	28	20.7	24	26
Wyoming	41	21.3	21	31

Source: Trust for America's Health, F as in Fat: How Obesity Politics Are Failing in America, 2005
Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005

TABLE F.2 OBESITY/SMOKING RANKINGS, RANK ORDERED, 2005

State	*Obesity/Smoking Average Ranking*	*State*	*Obesity/Smoking Average Ranking*
West Virginia	3	Maine	27.5
Kentucky	3.5	Florida	28
Tennessee	4	Illinois	28
Alabama	4.5	Minnesota	28.5
Mississippi	4.5	New Mexico	29
Indiana	5.5	New York	30.5
Louisiana	8.5	South Dakota	30.5
Oklahoma	9.5	Wyoming	31
Arkansas	10.5	Kansas	33.5
Pennsylvania	11.5	Arizona	34.5
Michigan	12	Maryland	34.5
Alaska	12.5	New Hampshire	35
South Carolina	12.5	Washington	37.5
Missouri	13.5	Oregon	38
Georgia	14.5	California	40
North Carolina	14.5	Idaho	40
Ohio	14.5	New Jersey	41
Texas	19	Rhode Island	41
Nebraska	20.5	Vermont	41
Nevada	22	Montana	41.5
North Dakota	23.5	Colorado	42
Virginia	23.5	Massachusetts	45
Iowa	24	Connecticut	46.5
Delaware	26	Utah	46.5
Wisconsin	26	Hawaii	47

Note: A low rank indicates a higher proportion of obese and current smoking adults

Source: Trust for America's Health, F as in Fat: How Obesity Politics Are Failing in America, 2005

Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005

TABLE F.3 STATE HEALTH RANKINGS, ALPHABETICAL BY STATE, 2005

State	*United Health Foundation 2005 America's Health Rankings*	*Morgan Quitno Press 2005 Healthiest State Award Rankings*	*Average of the two rankings*
Alabama	45	41	43
Alaska	30	37	33.5
Arizona	31	39	35
Arkansas	47	40	43.5
California	22	18	20
Colorado	17	27	22
Connecticut	7	10	8.5
Delaware	33	35	34
Florida	40	44	42
Georgia	43	42	42.5
Hawaii	5	8	6.5
Idaho	16	20	18
Illinois	28	34	31
Indiana	32	24	28
Iowa	10	6	8
Kansas	23	15	19
Kentucky	42	32	37
Louisiana	49	50	49.5
Maine	8	5	6.5
Maryland	34	29	31.5
Massachusetts	9	3	6
Michigan	29	23	26
Minnesota	1	4	2.5
Mississippi	50	49	49.5
Missouri	35	36	35.5
Montana	21	25	23

TABLE F.3 Continued

State	*United Health Foundation 2005 America's Health Rankings*	*Morgan Quitno Press 2005 Healthiest State Award Rankings*	*Average of the two rankings*
Nebraska	11	9	10
Nevada	37	47	42
New Hampshire	3	2	1.5
New Jersey	15	16	15.5
New Mexico	38	48	43
New York	26	31	28.5
North Carolina	36	33	34.5
North Dakota	6	11	8.5
Ohio	27	26	26.5
Oklahoma	44	46	45
Oregon	18	19	18.5
Pennsylvania	25	21	23
Rhode Island	12	12	12
South Carolina	46	43	44.5
South Dakota	20	22	21
Tennessee	48	38	43
Texas	39	45	42
Utah	4	7	5.5
Vermont	2	1	1.5
Virginia	24	17	20.5
Washington	14	13	13.5
West Virginia	41	28	34.5
Wisconsin	13	14	13.5
Wyoming	19	30	24.5

Note: The least healthy states have the highest rank ordered numbers

Source: United Health Foundation, America's Health Rankings, 2005 ed.
Morgan Quitno Press, Health Care State Rankings 2005

TABLE F.4 STATE HEALTH RANKINGS, RANK ORDERED, 2005

State	*Average of the United Health Foundation and Morgan Quitno 2005 State Health Rankings*	*State*	*Average of the United Health Foundation and Morgan Quitno 2005 State Health Rankings*
Louisiana	49.5	Wyoming	24.5
Mississippi	49.5	Montana	23
Oklahoma	45	Pennsylvania	23
South Carolina	44.5	Colorado	22
Arkansas	43.5	South Dakota	21
Alabama	43	Virginia	20.5
New Mexico	43	California	20
Tennessee	43	Kansas	19
Georgia	42.5	Oregon	18.5
Florida	42	Idaho	18
Nevada	42	New Jersey	15.5
Texas	42	Washington	13.5
Kentucky	37	Wisconsin	13.5
Missouri	35.5	Rhode Island	12
Arizona	35	Nebraska	10
North Carolina	34.5	Connecticut	8.5
West Virginia	34.5	North Dakota	8.5
Delaware	34	Iowa	8
Alaska	33.5	Hawaii	6.5
Maryland	31.5	Maine	6.5
Illinois	31	Massachusetts	6
New York	28.5	Utah	5.5
Indiana	28	Minnesota	2.5
Ohio	26.5	New Hampshire	1.5
Michigan	26	Vermont	1.5

Note: The least healthy states have the highest rank ordered numbers

Source: United Health Foundation, America's Health Rankings, 2005 ed.
Morgan Quitno Press, Health Care State Rankings 2005

TABLE F.5 GOVERNMENT PERFORMANCE PROJECT, PEOPLE RATING, 2005
ALPHABETICAL BY STATE

State	*GPP People Score*	*Numerical Equivalent*	*State*	*GPP People Score*	*Numerical Equivalent*
Alabama	C+	2.3333	Montana	C+	2.3333
Alaska	C+	2.3333	Nebraska	B-	2.6667
Arizona	B	3.0000	Nevada	C+	2.3333
Arkansas	C	2.0000	New Hampshire	C+	2.3333
California	C-	1.6667	New Jersey	B	3.0000
Colorado	C+	2.3333	New Mexico	C+	2.3333
Connecticut	B	3.0000	New York	B-	2.6667
Delaware	B-	2.6667	North Carolina	C+	2.3333
Florida	B-	2.6667	North Dakota	B-	2.6667
Georgia	A	4.0000	Ohio	B-	2.6667
Hawaii	B	3.0000	Oklahoma	B-	2.6667
Idaho	B	3.0000	Oregon	B-	2.6667
Illinois	C	2.0000	Pennsylvania	B-	2.6667
Indiana	C	2.0000	Rhode Island	D+	1.3333
Iowa	B	3.0000	South Carolina	A-	3.6667
Kansas	B-	2.6667	South Dakota	B-	2.6667
Kentucky	B	3.0000	Tennessee	C-	1.6667
Louisiana	B	3.0000	Texas	B	3.0000
Maine	B-	2.6667	Utah	B+	3.3333
Maryland	B-	2.6667	Vermont	B	3.0000
Massachusetts	C+	2.3333	Virginia	A-	3.6667
Michigan	B	3.0000	Washington	B+	3.3333
Minnesota	B+	3.3333	West Virginia	C	2.0000
Mississippi	C+	2.3333	Wisconsin	B	3.0000
Missouri	B-	2.6667	Wyoming	D+	1.3333

Source: The Pew Center for the States (2005). *Government Performance Project, Grading the States 2005: A Look Inside.*

TABLE F.6 GOVERNMENT PERFORMANCE PROJECT, PEOPLE RATING, 2005
RANK ORDERED BY STATE

State	*GPP People Score*	*Numerical Equivalent*	*State*	*GPP People Score*	*Numerical Equivalent*
Georgia	A	4	New York	B-	2.6667
South Carolina	A-	3.6667	North Dakota	B-	2.6667
Virginia	A-	3.6667	Ohio	B-	2.6667
Minnesota	B+	3.3333	Oklahoma	B-	2.6667
Utah	B+	3.3333	Oregon	B-	2.6667
Washington	B+	3.3333	Pennsylvania	B-	2.6667
Arizona	B	3	South Dakota	B-	2.6667
Connecticut	B	3	Alabama	C+	2.3333
Hawaii	B	3	Alaska	C+	2.3333
Idaho	B	3	Colorado	C+	2.3333
Iowa	B	3	Massachusetts	C+	2.3333
Kentucky	B	3	Mississippi	C+	2.3333
Louisiana	B	3	Montana	C+	2.3333
Michigan	B	3	Nevada	C+	2.3333
New Jersey	B	3	New Hampshire	C+	2.3333
Texas	B	3	New Mexico	C+	2.3333
Vermont	B	3	North Carolina	C+	2.3333
Wisconsin	B	3	Arkansas	C	2
Delaware	B-	2.6667	Illinois	C	2
Florida	B-	2.6667	Indiana	C	2
Kansas	B-	2.6667	West Virginia	C	2
Maine	B-	2.6667	California	C-	1.6667
Maryland	B-	2.6667	Tennessee	C-	1.6667
Missouri	B-	2.6667	Rhode Island	D+	1.3333
Nebraska	B-	2.6667	Wyoming	D+	1.3333

Source: The Pew Center for the States (2005). *Government Performance Project, Grading the States 2005: A Look Inside.*

TABLE F.7 AVERAGE AGE OF STATE GOVERNMENT EMPLOYEES, 2002
ALPHABETICAL BY STATE

State	*Average Age*	*State*	*Average Age*
Alabama	42.75	New Hampshire	44.00
Alaska	44.00	New Jersey	45.00
Arizona	44.00	New Mexico	42.25
Arkansas	44.00	New York	45.25
California	42.75	North Carolina	42.75
Colorado	44.50	North Dakota	45.00
Delaware	41.50	Ohio	48.00
Georgia	43.00	Oklahoma	45.00
Idaho	47.00	Oregon	44.00
Illinois	45.25	Pennsylvania	46.00
Indiana	45.00	Rhode Island	48.00
Iowa	46.00	South Carolina	44.00
Kansas	44.75	South Dakota	43.00
Kentucky	43.00	Texas	42.50
Louisiana	43.00	Utah	42.00
Michigan	44.00	Vermont	43.50
Minnesota	46.00	Virginia	44.50
Mississippi	42.25	Washington	47.00
Missouri	42.00	Wisconsin	44.25
Montana	45.00	Wyoming	44.50
Nevada	44.25		

Data not available for Connecticut, Florida, Hawaii, Maine, Maryland, Massachusetts, Nebraska, Tennessee, West Virginia

Source: Carroll and Moss (2002), *State Employee Worker Shortage, the Impending Crisis*

TABLE F.8 AVERAGE AGE OF STATE GOVERNMENT EMPLOYEES, 2002
RANK ORDERED BY STATE

State	*Average Age*	*State*	*Average Age*
Delaware	41.5	Nevada	44.25
Missouri	42	Wisconsin	44.25
Utah	42	Colorado	44.5
Mississippi	42.25	Virginia	44.5
New Mexico	42.25	Wyoming	44.5
Texas	42.5	Kansas	44.75
Alabama	42.75	Indiana	45
California	42.75	Montana	45
North Carolina	42.75	New Jersey	45
Georgia	43	North Dakota	45
Kentucky	43	Oklahoma	45
Louisiana	43	Illinois	45.25
South Dakota	43	New York	45.25
Vermont	43.5	Iowa	46
Alaska	44	Minnesota	46
Arizona	44	Pennsylvania	46
Arkansas	44	Idaho	47
Michigan	44	Washington	47
New Hampshire	44	Ohio	48
Oregon	44	Rhode Island	48
South Carolina	44		

Data not available for Connecticut, Florida, Hawaii, Maine, Maryland, Massachusetts, Nebraska, Tennessee, West Virginia

Source: Carroll and Moss (2002), *State Employee Worker Shortage, the Impending Crisis*